LuxSmile
FAMILY DENTISTRY

PATIENT REGISTRATION

PATIENT FULL NAME: _____ **DATE:** _____
(First, Middle, Last)

PATIENT IS: □ Responsible Party □ Policy Holder □ Dependent (check all that apply)

PATIENT INFORMATION:

Address:_____
City, State, Zip:_____
Birth Date:_____ / _____ / _____ Social Security #: _____-_____-_____
Sex: □ Female □ Male Employer: _____
Marital Status: □ Single □ Married □ Divorced □ Widowed

Please fill out **ALL** contact numbers and email. Check the BEST methods to contact you (check all that apply):
____ Cell Phone:_____
____ Work Phone:_____
____ Home Phone:_____
____ Email:_____

RESPONSIBLE PARTY (if someone other than the patient):

Full Name: _____
Relationship to patient: _____ Has Existing Account at this office? Yes No
Address: _____
City, State, Zip: _____
Home Phone: _____Work Phone: _____Cell Phone:_____
Birth Date:_____ / _____ / _____ Social Security #: _____-_____-_____

How will you be making your payment at time of your appointment?
□ **Visa** □ **MC** □ **American Express** □ **Discover** □ **CareCredit** □ **Cash**

INSURANCE INFORMATION:

PRIMARY INSURANCE	**SECONDARY INSURANCE**
Name of Insured: _____	Name of Insured: _____
Insured Social Security #: _____-_____-_____	Insured Social Security #: _____-_____-_____
Insured Birth Date: _____ / _____ / _____	Insured Birth Date: _____ / _____ / _____
Relationship to Patient:	Relationship to Patient:
____ Self	____ Self
____ Spouse	____ Spouse
____ Child	____ Child
____ Other:_____	____ Other:_____
Employer: _____	Employer: _____
Insurance Company: _____	Insurance Company: _____
Insurance Co. Phone #: _____	Insurance Co. Phone #: _____
Address: _____	Address: _____
City, State, Zip: _____	City, State, Zip: _____
Group #: _____	Group #: _____
ID #: _____	ID #: _____

EMERGENCY CONTACT:

Name:_____

Relationship:_____ Phone Number:_____

Physician's Name and Phone Number:_____

Preferred Pharmacy Name and Phone Number:_____

OTHER INFORMATION:

Is another member of your family a patient at our office? Yes No

If yes, Name:_____ Relationship_____

CONSENT FOR TREATMENT/ INSURANCE ASSIGNMENT/ FINANCIAL RESPONSIBILITY/ OFFICE POLICIES:

1. I hereby authorize the doctor or designated staff to take radiographs (x-rays), study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of this patient's dental needs. I authorize the doctor, following appropriate diagnosis, to perform all recommended treatment mutually agreed upon by the patient, or representative of the patient, and the doctor.
2. I agree to the use of anesthetics or other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of these risks.
3. I hereby authorize LuxSmile Family Dentistry to furnish information to insurance carriers concerning my dental needs and treatment, and I hereby assign to LuxSmile Family Dentistry all payments for services rendered to my dependents or myself. I understand that I am ultimately responsible for full payment of all charges, and LuxSmile Family Dentistry makes no guarantees of my insurance reimbursement.
4. I understand that I am financially responsible for any and all unpaid amounts incurred in treatment. I understand accounts that are 30 days past due are subject to a minimum service charge of $5.00 or 2.5% of the outstanding balance per month, whichever is greater.
5. I understand that if my account remains unpaid and is forwarded to a collection agency, I will be responsible for any reasonable collection costs, including reasonable attorney fees. I understand that, if required, a check of my credit history may be made.
6. I understand that in the event that my check is returned to LuxSmile Family Dentistry from the bank, I will be charged $30.00. I understand that I will be required to pay the amount of the original check plus the service fee within five business days by cashier's check, money order, cash, or credit card. If I fail to do this, my account may be turned over to a collection agency.
7. I understand that a minimum of 24 hrs. notice is required for cancellation of appointments. A broken appointment fee may be charged to my account and is payable by me if a 24 hour notice is not given.

Patient/Guardian Signature:_____Date:_____

Responsible Party's Signature:_____Date:_____
(if different than patient)

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DENTAL HISTORY

PATIENT: _____ **DATE:** _____
(First, Middle, Last)

1) Purpose of this appointment: _____
Problems / Concerns: _____

2) Please provide date:
Last Dental Visit _____Last Dental Cleaning_____Last Full Mouth X-rays_____

3) What was done at your last visit? _____

4) Previous Dentist's Name: _____
Address: _____
Phone: _____

5) How often do you have dental examinations? _____

6) How often do you brush your teeth? _____How often do you floss? _____
What other dental aids do you use? (toothpick, interplak, etc.) _____

7) Have you ever had unhappy dental experiences? Yes No
If yes, please explain: _____

8) Have you ever had any injuries to your mouth / teeth / head? Yes No
If yes, please explain: _____

9) Do you have any jaw issues? (clicking / popping / pain) Yes No
If yes, please explain: _____

10) Do you mouth-breath / snore? Yes No
If yes, please explain: _____

11) Have you ever had:
Orthodontic treatment? Yes No
Periodontal treatment? Yes No
Oral surgery? Yes No

12) Are any of your teeth sensitive to:
Hot or cold? Yes No
Sweets? Yes No
Biting or Chewing? Yes No

13) Please describe anything else about your dental health or having dental treatment that you would like us to know: _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. I am aware that all information is confidential.

Patient / Guardian Signature: _____ Date: _____

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MEDICAL HISTORY

PATIENT FULL NAME: _____DOB:_____
(First, Middle, Last)

Are you under a physician's care now? Yes No
If yes, please explain: _____

Are you taking any medications, pills, or drugs? Yes No
If yes, please list here: _____

Are you taking any blood thinner (i.e. aspirin, Plavix, Pradaxa, or Coumadin)? Yes No
If yes, please list: _____

Have you ever been hospitalized or had a major operation? Yes No
If yes, please explain: _____

Have you ever had a serious head or neck injury? Yes No
If yes, please explain: _____

Do you need to pre-medicate? Yes No
If yes, please explain: _____

Do you have any physical conditions we should be aware of? Yes No
If yes, please list: _____

Do you have any medical conditions we should be aware of? Yes No
If yes, please list: _____

Are you on a special diet? Yes No

Do you use tobacco? Yes No

Do you use controlled substances? Yes No

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No

Are you **Allergic** to any of the following?
Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa
Other, please list: _____

Women Only:
Pregnant / trying to get pregnant? Yes No Taking Birth Control Pills? Yes No Nursing? Yes No

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes	No	Diabetes	Yes	No
Alzheimer's disease	Yes	No	Emphysema	Yes	No
Anaphylaxis	Yes	No	Epilepsy or Seizures	Yes	No
Anemia	Yes	No	Excessive Bleeding	Yes	No
Angina	Yes	No	Excessive Thirst	Yes	No
Arthritis/Gout	Yes	No	Fainting Spells/Dizziness	Yes	No
Artificial Heart Valve	Yes	No	Frequent Cough	Yes	No
Artificial Joint	Yes	No	Frequent Headaches	Yes	No
Asthma	Yes	No	Glaucoma	Yes	No
Autism	Yes	No	Hay Fever	Yes	No
Blood Disease	Yes	No	Heart Attack/Failure	Yes	No
Blood Transfusion	Yes	No	Heart Murmur	Yes	No
Breathing Problem	Yes	No	Heart Pace Maker	Yes	No
Bruise Easily	Yes	No	Heart Trouble/Disease	Yes	No
Cancer	Yes	No	Hemophilia	Yes	No
Chest Pains	Yes	No	Hepatitis A, B, or C	Yes	No
Cold Sores/Fever Blisters	Yes	No	High Blood Pressure	Yes	No
Congenital Heart Disorder	Yes	No	High Cholesterol	Yes	No
Convulsions	Yes	No	Hives or Rash	Yes	No
Cortisone Medicine	Yes	No	Hypoglycemia	Yes	No
Irregular Heartbeat	Yes	No	Rheumatism	Yes	No
Kidney Problems	Yes	No	Scarlet Fever	Yes	No
Leukemia	Yes	No	STD	Yes	No
Liver Disease	Yes	No	Shingles	Yes	No
Low Blood Pressure	Yes	No	Sickle Cell Disease	Yes	No
Lung Disease	Yes	No	Sinus Trouble	Yes	No
Mitral Valve Prolapse	Yes	No	Spinal Bifida	Yes	No
Osteoporosis	Yes	No	Stomach/Intestinal Disease	Yes	No
Pain in Jaw Joints	Yes	No	Stroke	Yes	No
Parathyroid Disease	Yes	No	Swelling of Limbs	Yes	No
Psychiatric Care	Yes	No	Thyroid Disease	Yes	No
Radiation Treatments	Yes	No	Tonsillitis	Yes	No
Recent Weight Loss	Yes	No	Tumors or Growths	Yes	No
Renal Dialysis	Yes	No	Ulcers	Yes	No
Rheumatic Fever	Yes	No	Yellow Jaundice	Yes	No

Please explain all YES answers here:

_____
_____
_____

Do you have or have you had any other serious illnesses or conditions not listed on this form? If yes, please explain:

_____
_____
_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____ _____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN DATE

LuxSmile
FAMILY DENTISTRY
3320 E. Hebron Parkway, Suite #112
Carrollton, TX 75010
(972) 698-5988

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

The Health Insurance and Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical and dental records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are properly kept confidential. HIPAA gives you, the patient, significant rights to understand and control how your health information is used.

HIPAA provides penalties for covered entities, including our Practice, that misuse "protected health information" (PHI). PHI is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services. We are required by law to maintain the privacy of your PHI and to provide you with this notice of our legal duties and privacy practices with respect to your PHI. We also have legal obligations to notify you in the event of a breach of unsecured PHI.

This Notice of Privacy Practices describes how we may use and disclose your PHI for treatment, payment, health care operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. This Notice of Privacy Policies takes effect on 09/22/2013 and remains in effect until we replace it. We are required to abide by the terms of the Notice of Privacy Practices that is in effect.

We reserve the right to change our privacy practices and the terms of this Notice of Privacy Practices at any time, provided such changes are permitted by applicable law. We reserve the right to make any changes in our privacy practices effective for all PHI that we maintain, including health information we created or received before we made the changes. In the event of a change in our practices, we will provide you with a copy of the revised Notice of Privacy Practices through one or more of the following methods: posting the Notice of Privacy Practices to our website, mailing you a copy, or providing you a copy at your next appointment with us.

You may request a copy of our current Notice of Privacy Practices at any time. For more information about our practices, or for additional copies, please contact us using the information listed at the end of this Notice.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you a nominal fee for each page and per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances, if any, in which we or our business associates or their subcontractors disclosed your PHI for purposes other than treatment, payment, healthcare operations, and other permitted uses as described in this Notice of Privacy Practices, for the last 3 years. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests. You have the right to request such an accounting in an electronic format.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. {You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you have any concerns that we may have violated your privacy rights, or if you disagree with a decision we made about access to your PHI or in response to a request you made to amend or restrict the use or disclosure of your PHI, or to have us communicate with you by alternative means or at alternative locations, you may contact us using the information listed below.

In addition, you may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the contact information for filing a complaint upon request. We support your right to the privacy of your PHI. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

If you would like additional information regarding our privacy practices, or if you have questions or concerns, please contact us as indicated below.

Contact Officer: John Ngo
Telephone: (972) 698-5988
Fax: (972) 698-5988
Address: 3320 E. Hebron Parkway, Suite #112, Carrollton, TX 75010

Patient Signature: _____ Date: _____