FAMILY DENTISTRY

Greg J Frei, DDS
Lisa Hollingsworth, DDS

Patient Name: _____ **Reason for this visit:** _____

Health Information

Have you ever had any of the following? Please check yes or no.

Y	N		Y	N		Y	N	
☐	☐	AIDS/HIV Positive	☐	☐	Glaucoma	☐	☐	Pacemaker
☐	☐	Allergies	☐	☐	Growths	☐	☐	Radiation Treatment
☐	☐	Allergies to medications _____	☐	☐	Hay Fever	☐	☐	Respiratory Problems
			☐	☐	Head Injuries	☐	☐	Rheumatic Fever
☐	☐	Allergy to Sulfur/Sulfa Drugs	☐	☐	Heart Disease	☐	☐	Stomach Problems
☐	☐	Arthritis _____	☐	☐	Heart Murmur	☐	☐	Stroke
☐	☐	Artificial Joints	☐	☐	Hepatitis	☐	☐	Thyroid Problems
☐	☐	Asthma	☐	☐	High Blood Pressure	☐	☐	Tuberculosis
☐	☐	Blood Disease	☐	☐	IV Bisphosphonate Therapy (Aredia, Zometa)	☐	☐	Tumors
☐	☐	Blood Transfusion	☐	☐	Jaundice	☐	☐	Ulcers
☐	☐	Cancer	☐	☐	Kidney Disease	☐	☐	Venereal Disease
☐	☐	Diabetes	☐	☐	Liver Disease	☐	☐	OTHER
☐	☐	Dizziness	☐	☐	Lung Problems			
☐	☐	Epilepsy	☐	☐	Mental Disorders			_____
☐	☐	Excessive Bleeding	☐	☐	Might you be Pregnant?			
☐	☐	Fainting	☐	☐	Osteoporosis Therapy (Fosamax, Actonel, Boniva)			

Are you now under the care of a physician? ☐ Yes ☐ No Physician: _____ Phone: _____

If yes please explain: _____

Have you been to a hospital, needed emergency care or have had surgery during the past two years? ☐ Yes ☐ No

If yes, please explain: _____

Please list any medications you are currently taking: _____

Do you regularly take herbal medicines or dietary supplements? ☐ Yes ☐ No Specifically, Do you take **(circle all that apply):**

Echinacea Fish Oil Garlic Ginger Gingko Ginseng Kava St. John's Wort Valerian Vitamin E

Are you on a special diet? _____ Do you use tobacco products? _____ Other: _____

Have you ever had any complications following dental treatment? ☐ Yes ☐ No

If yes, please explain: _____

Do you have any health problems that need further clarification? ☐ Yes ☐ No

If yes please explain: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives and 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 any possible complications. I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions of treatment and payment and agree to their content.

_____ Signature of patient, parent or guardian

_____ Relationship to Patient

_____ Date

FAMILY DENTISTRY

Greg J. Frei, DDS
Lisa Hollingsworth, DDS

Patient Registration

Date: _____

Patient Name: _____ Birth Date: _____ **M** **F**
First MI Last

Address: _____
Street Apt# City State Zip Code

Phone: Home or Cell _____ SSN # _____

Whom may we thank for referring you to our practice?

☐ Another patient ☐ Postcard ☐ School ☐ Sign ☐ Yellow Pages ☐ Other _____

Name of person or Office referring you to our practice: _____

Responsible Party Information (GUARANTOR)

Name: _____
First MI Last Relationship to the patient

Address: _____
Street Apt# City State Zip Code

Social Security No.: _____ Date of Birth _____ Home Phone: _____

Employer: _____ Work Phone: _____ Cell Phone: _____

Spouse's Name: _____ Contact Phone: _____

Emergency Contact/Relationship _____ Contact Phone: _____

Insurance Information

☐ **Employer Group Policy** ☐ **Self Insured**

Policy Holder's Name: _____ Policy Holder's Birth Date: _____
First MI Last

Policy Holder's Address: _____
Street Apt# City State Zip Code

Patient's relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Dental Insurance Plan: _____ ID# _____ Grp# _____

Insurance Address/Phone: _____

Policy Holder's Employer: _____

This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. Insurance coverage is not a guarantee of benefits. **GUARANTOR SHALL BE RESPONSIBLE FOR ALL UNPAID CLAIMS.**

_____ _____
Signature of patient, parent or guardian **Date**

Gregory J Frei, DDS
Lisa Hollingsworth, DDS
Phone: 830-438-2273

22101 State Hwy 46 West
Spring Branch, TX 78070
Fax: 830-438-3183

PATIENT INFORMATION

I pride myself in treating patients like family, and providing them a dental office where they know my ethics, education, and sincere care for them is second to none. We know that the information below can be an uncomfortable subject, but we feel that being clear on these issues now will avoid misunderstandings.

_____**APPOINTMENTS:** We ask that you arrive 10 minutes early to update necessary medical history forms. If you have moved, changed your phone number, or insurance please notify the receptionist, so that your file can be updated appropriately. **If you are more than 10 minutes late, we may require you to reschedule your appointment.**

_____ **CANCELLATIONS:** We ask that you notify us at least 24 hours in advance if you cannot keep your appointment. **Patients who do not notify the office that they are unable to keep their appointment at least 24 hours in advance may be charged a fee of $25.00**

_____ **PAYMENTS:** Regardless of your insurance coverage, you are ultimately responsible for payment in full. We ask that you keep your balance current. **All deductibles, co-insurance, and estimated patient portion(s)** are due and payable at the time of each visit.

_____ **INSURANCE:** All levels of payment by insurance companies, including allowed fees, usual and customary (**UCR**), are governed by the premiums paid. They have nothing to do with the actual charges. Our fees are based upon a combination of our costs, our time, and our constant dedication to supplying our patients with the highest quality dental care. The treatment recommended by our office is never based on what your insurance company will pay; your treatment should not be governed by your insurance contract.

However, it should be understood, that the dental insurance contract is between the insurance company and the patient, whom bears the ultimate financial responsibility.

_____**GUARDIAN OF A MINOR:** In the case of guardianship, the parent who brings in the minor child is responsible for payment. We do not negotiate through a Third Party. It will be your responsibility to seek reimbursement.

_____**RETURNED CHECKS (NSF):** Pursuant to SB-921, you will have 10 days to tender payment, plus a $30.00 bank service charge, on all returned checks. If payment is not received within that period, the check will be forwarded to the District Attorney's Office.

_____**DELINQUENT ACCOUNT:** To maintain our facilities and continue to provide quality healthcare service, we must keep our reimbursements current. If your account becomes ninety (90) days delinquent it may be placed in collections and there will be an additional $30.00 processing fee. It is important to remember that the relationship for payment is between you and your insurance carrier. We simply, as a courtesy, file the claim for the services that are provided. It is your responsibility to understand your benefits. If you have questions regarding the coverage, please contact your insurance carrier and/or employer.

_____**DENTAL RECORDS:** Your dental record is the property of ***Frei Dentistry, P.A***. If another Dentist who is treating you (or your child) requests a copy of your dental record, this will be provided to them at no charge, with a signed medical release authorization. If you choose to obtain a copy for yourself, then a $25.00 charge can be applied. This fee will be in accordance with the guidelines established by the Texas State Board of Dental Examiners.

Thank you,
Gregory J Frei, DDS
Lisa Hollingsworth, DDS

_____

Patient – Parent – Guardian Signature ***Date***

BNFD11072013 - revised

Bulverde North Family Dental
22101 State Hwy 46 West
Spring Branch, Texas 78070

Gregory J Frei, DDS
Lisa Hollingsworth, DDS

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITYS IN THE FUTURE.

_____ Please ***print*** your name *(patient)*

_____ Please ***sign*** your name *(patient)*

_____ Legal Representative *(if patient is a minor)*

_____ Description of Authority *(relationship to patient)*

Your comments regarding Acknowledgements or Consents: _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Home Phone Confirmation _____
☐ Cell Phone Confirmation _____
☐ Text Message to my Cell Phone
☐ Work Phone Confirmation _____
☐ Email Confirmation _____
☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Home Phone Confirmation _____
☐ Cell Phone Confirmation _____
☐ Text Message to my Cell Phone
☐ Work Phone Confirmation _____
☐ Email Confirmation _____
☐ **Any of the Above**

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment _____
I could not communicate with the patient _____
The patient refused to sign _____
The patient was unable to sign because _____
Other (please describe) _____

_____
Signature of Privacy Officer – Gregory J Frei, DDS