TIME 04:11 PM DATE 10/3/2016

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

Referred By:

General DDS Name:

General DDS Phone:

Emergency Contact:

Emerg Contact Phone:

Relationship:

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

PATIENT MEDICAL HISTORY

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	Yes No	If yes
Have you ever been hospitalized or had a major operation?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Are you taking any medications, pills, or drugs?	Yes No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Are you on a special diet?	Yes No	
Do you use tobacco?	Yes No	

Women: Are you...

- Pregnant/Trying to get pregnant?
- Nursing?
- Taking oral contraceptives?

Are you allergic to any of the following?

- Aspirin
- Penicillin
- Codeine
- Acrylic
- Metal
- Latex
- Sulfa Drugs
- Local Anesthetics

Do you use controlled substances?	Yes No	If yes
Other?		If yes

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

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

Have you ever had any serious illness not listed	Yes No	If yes

Comments:

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 patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X_____ Date:_____

Dental Questionnaire

Your Dentist's Name _____ for how long:_____

How frequently have you had your teeth cleaned during the past 5 years:

❑less than once a year ❑once a year ❑twice a year ❑three times a year ❑four times a year

Mo/Year of your last dental exam_____ Mo/Year of your last dental x-rays_____

Are you presently satisfied with the condition of your mouth and teeth(circle one):

❑very satisfied ❑satisfied ❑it's o.k. ❑somewhat dissatisfied ❑very dissatisfied

YES NO

❑ ❑ Do you presently have any pain, discomfort or impaired function related to your mouth?
If yes, please describe? _____

❑ ❑ Are you currently aware of any infection in your mouth?
If yes, please describe: _____

❑ ❑ Are you currently taking any antibioitics for infection? If so, what: _____

❑ ❑ Do your gums ever bleed? If so, when: _____

❑ ❑ Do you have a problem with bad breath or have any friends or family made you aware of this?

❑ ❑ Are you interested in replacing lost teeth?

❑ ❑ Do you ever have aches or pains in your jaw joints, ears, face, neck or head?

❑ ❑ Are any of your teeth tender when you chew hard foods?

❑ ❑ Are any of your teeth more sensitive to: cold, hot, sweets, certain foods or drinks?

❑ ❑ Are any particular teeth very sensitive or painful? when? _____

❑ ❑ Are you concerned about gum recession around any of your teeth?

❑ ❑ Are you concerned about the appearance of your teeth or mouth?

❑ ❑ Have you ever had Orthodontic treatment? ❑with braces ❑with removable appliances
When did you go through Orthodontic care? _____

❑ ❑ Have you ever received Periodontal treatment? ❑scaling/root planing ❑gum surgery
When did you go through Periodontal care? _____

Check any of the following that describe you or makes dental treatment easier for you:

❑ I tolerate most dental care reasonably well and usually require minimal use of anesthesia
❑ I aprpeciate the use of local anesthetic – it allows me to tolerate most dental care reasonably well
❑ I tolerate shots in my mouth when they are given well
❑ I like the benefits of nitrous oxide (laughing gas)
❑ I prefer to be sedated for any surgical treatment
❑ I prefer to be sedated for any lengthy surgical care
❑ I have a hard time sitting in the dental chair for more than an hour
❑ I have a hard time sitting in the dental chair very long due to a neck, back, spine problem
❑ I have difficulty when tilted back in the dental chair (dizziness, breathing difficulty, _____

What are your goals or priorities for the health, function and appearance of your teeth & mouth:
(rate each item from 1 to 5 with 1 being your lowest priority and 5 your highest – you can use the same number more than once)

____be able to chew food and eat what I enjoy
____preserve my teeth & avoid dentures
____be free of infection
____be free of mouth pain & tenderness
____ avoid removable bridgework
____ for my mouth to look nice when I smile
____ make my teeth look good
____ have a healthy and hassle-free mouth

_____ _____ _____

Signature of patient or legal guardian Date Reviewed by

Syed A. Khalid, D.D.S., M.S.
Tareq I. Beck, D.D.S., M.S.
11451 Katy Freeway, Suite 105
Houston, Texas 77079
O (713) 465-8239 F (713) 465-5942
prestigeperio2014@gmail.com
www.HoustonLANAP.com

FINANCIAL POLICY

Thank you for choosing our practice! Our primary mission is to deliver the best and most comprehensive optimal dental care available. An important part of this mission is making the cost as effortless and manageable as possible for our patients by providing a clear Financial Policy and offering several payment options.

- For all surgery cases, a 25% deposit is required in advance to secure your surgery appointment.
- Our practice requires payment in full at the time of your treatment or surgery. If we will be utilizing your insurance benefits, we are happy to work with your carrier to maximize your benefits.
- **Unless our office is notified 48 hours in advance of your surgery appointment, we will assess a $200 cancellation fee.**

Payment Options:

Accepted Payment Methods:

- Cash, Check, Visa, MasterCard, American Express, and Discover
- HealthCare Financing through CareCredit, Lending Club, and United Medical Credit

If you have any questions or concerns, please do not hesitate to ask. We are here to help you receive the care that you need in an affordable manner.

I have had an opportunity to review the Financial Policy and to ask questions regarding financial arrangements. I agree with the terms that are explained in this policy.

x _____
Patient Name (Please Print)

x _____
Patient or Parent/Guardian Signature Date

_____
Witness

Acknowledgement of Receipt:
HIPAA Notice of Privacy Practices

Last Updated: September 27, 2016

for the practice of

PRESTIGE PERIODONTAL & DENTAL IMPLANT SURGERY
11451 Katy Freeway, Suite 105
Houston, Texas 77079
(713) 465-8239
prestigeperio2014@gmail.com

Acknowledgement

I, _____, hereby acknowledge that I have received and reviewed a copy of "*HIPAA Notice of Privacy Practices*" for the practice of Prestige Periodontal & Dental Implant Surgery.

I understand that this practice's "*HIPAA Notice of Privacy Practices*" may change periodically and that I am entitled to receive a copy of the revised "*HIPAA Notice of Privacy Practices*" upon request.

I understand that, if I have questions about Prestige Periodontal's "*HIPAA Notice of Privacy Practices*", I may contact the Office Manager at (713) 465-8239 or prestigeperio2014@gmail.com.

I understand that it is my right to refuse to sign this Acknowledgement should I so choose, and that this practice will not refuse treatment to me if I refuse to sign this Acknowledgement.

I further understand that I may contact the Secretary of the U.S. Department of Health and Human Services should I have concerns regarding this practice's privacy policies and procedures.

_____ Patient Signature	_____ Date
_____ Signature of Personal Representative	_____ Print Name of Personal Representative
	_____ Relationship of Personal Representative to Patient

FOR OFFICE USE ONLY

The office of Prestige Periodontal made a good-faith effort to obtain Acknowledgement from the patient noted above and to obtain receipt of its "*HIPAA Notice of Privacy Practices*". In spite of these efforts, this office was unable to obtain a signed Acknowledgement for the following reason(s):

- ☐ Refusal to sign Acknowledgement on _____, 20_____.
- ☐ Communication barriers prohibited us from obtaining a signed Acknowledgement.
- ☐ An emergency situation prohibited us from obtaining a signed Acknowledgement.
- ☐ Other (Describe):_____

Date Received	By	Patient ID