Fresh Dental
Family & Implant Center

New Patient Registration Update

We require the following information to serve you properly. All information is strictly confidential. **Please fill out completely. Thank you.**

Patient Information: Today's Date: _____

Name: _____ Middle Initial:_____ Preferred Name:_____

DOB: _____ Age: _____ Social Security: _____/_____/_____ Sex: ( M ) ( F ) ( OTHER )

Marital Status: ▢ Single ▢ Married ▢ Divorced ▢ Widowed Is your spouse/partner a current patient? ( Y ) ( N )

Mobile Phone: _____ Home/Work Phone: _____

Would you like to receive text reminders? ( Y ) ( N ) Email: _____

Address:_____ City:_____ State:_____ Zip:_____

Emergency Contact:

Name: _____ Relationship to Patient:_____

Mobile Phone: _____ Home/Work Phone: _____

Email: _____

How did you hear about our office?

▢ Google ▢ Facebook ▢ Instagram ▢ Yelp ▢ Friend ▢ Insurance Carrier ▢ OTHER: _____

Did anyone specifically refer you to us? ( Y ) ( N ) If yes, name of referral: _____

Reason for today's visit:

▢ General Exam & X-rays / Cleaning ▢ In Pain / Emergency Visit ▢ Invisalign ▢ Second Opinion / Consultation

Today's Main Concern: _____

Insurance Information: Do you have Dental Insurance? ( Y ) ( N )

If you chose ( Y ) and did not provide dental insurance PRIOR to your appointment, please inform the front desk at this time if you are wanting to use insurance benefits.

# Medical and Dental History

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When was the patient's last visit to the dentist/dental cleaning? (Estimate) _____

Has the patient ever been to an Orthodontist? ( Y ) ( N )

What are the patient's current concerns/interests? Please select ALL that apply:

Healthy teeth ▢ White teeth ▢ Straight teeth ▢ Veneers ▢ Implants ▢ Other ▢_____

Does the patient have a current physician? ( Y ) ( N )

Physician Name and Phone Number:

_____

Date of Last Exam _____ Reason for last visit_____

**Does the patient need to premedicate prior to dental treatment?** ( Y ) ( N )

Do you have any of the following medical conditions? **PLEASE INDICATE ( N ) IF YOU DO NOT HAVE IT.**

| ( Y ) ( N ) | ( Y ) ( N ) | ( Y ) ( N ) |
|---|---|---|
| ▢ ▢ AIDS or HIV | ▢ ▢ Drug Addiction | ▢ ▢ Liver Disease |
| ▢ ▢ Allergies | ▢ ▢ Emphysema | ▢ ▢ Low Blood Pressure |
| ▢ ▢ Alzheimer's Disease | ▢ ▢ Epilepsy | ▢ ▢ Lung Disease |
| ▢ ▢ Anemia | ▢ ▢ Excessive Bleeding | ▢ ▢ Osteoporosis |
| ▢ ▢ Angina (Chest Pain) | ▢ ▢ Fainting | ▢ ▢ Pacemaker |
| ▢ ▢ Anxiety | ▢ ▢ Frequent Headaches | ▢ ▢ Radiation |
| ▢ ▢ Arthritis | ▢ ▢ Genital Herpes | ▢ ▢ Respiratory Problems |
| ▢ ▢ Asthma | ▢ ▢ Glaucoma | ▢ ▢ Rheumatism |
| ▢ ▢ Blood Disease | ▢ ▢ Gout | ▢ ▢ Scarlet Fever |
| ▢ ▢ Breathing Problems | ▢ ▢ Hay Fever | ▢ ▢ Seizures |
| ▢ ▢ Bruise Easily | ▢ ▢ Heart Conditions | ▢ ▢ Sinus Problems |
| ▢ ▢ Cancer | ▢ ▢ Hepatitis | ▢ ▢ Sleep Apnea |
| ▢ ▢ Chemotherapy | ▢ ▢ High Blood Pressure | ▢ ▢ Stomach Problems |
| ▢ ▢ Cold Sores | ▢ ▢ Hives/Rash | ▢ ▢ Stroke |
| ▢ ▢ COPD | ▢ ▢ HPV | ▢ ▢ Thyroid Disease |
| ▢ ▢ Cortisone Therapy | ▢ ▢ Jaundice | ▢ ▢ Tonsilitis |
| ▢ ▢ Depression | ▢ ▢ Jaw Joint Issues | ▢ ▢ Tuberculosis |
| ▢ ▢ Diabetes | ▢ ▢ Kidney Disease | ▢ ▢ Ulcers |

If Yes or you have any other medical condition, please describe:

Please list all medications / vitamins / supplements that you are now taking:

_____

_____

_____

Please list all known allergies (Local anesthetics, Penicillin or any antibiotics, Sulfa Drugs, Aspirin or Codeine?):

_____

_____

Have you ever been hospitalized for any surgical operation or serious illness? ( Y ) ( N )

If yes, please describe:

_____

Have you received radiation therapy to the head and neck area for cancer? ( Y ) ( N )

If yes, when was it?

_____

Have you taken any bisphosphonate for bone density (Osteoporosis) such as alendronate (Fosamax), risedronate (Actonel), and ibandronate (Boniva), pamidronate (Aredia), and zoledronic acid (Reclast/Zometa)? ( Y ) ( N )

If yes, was it delivered as oral pills or via vein? How long have you taken the medication?

_____

# Women only:

a) Are you pregnant? ( Y ) ( N )
b) Do you think you may be pregnant? ( Y ) ( N )
c) Are you nursing? ( Y ) ( N )
d) Are you taking Birth Control Pills? ( Y ) ( N )

_____ _____

Patient Signature Date

## What to Expect at Your First Visit

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I understand that my treatment today may include the following:

- Taking of radiographs (x-rays)
- Recording of periodontal probe depth measurements to check gum health and to assess which type of cleaning is needed
- Removal of plaque and calculus with a metal instrument and/or ultrasonic scaler
- Oral irrigation of gingival pockets
- Flossing of teeth
- Application of fluoride
    - Benefits of fluoride: Prevents formation of new cavities, remineralizer damage tooth structure, prevents further breakdown of tooth structure in an acidic environment
- Oral cancer screening and dental exam
- Coronal polishing

## What to Expect at Your Second Visit*

Types of Dental Cleanings:

- Prophylaxis (Prophy) cleaning or healthy mouth cleaning is diagnosed by the doctor when:
    - Minimal or no gingival inflammation (gingivitis)
    - Minimal or no calculus (plaque present)
    - Probing depths are 1-3 mm
    - Minimal or no bone loss
    - Minimal or no calculus below the gum line

- Deep Cleaning or Scaling and Root Planing (SRP) is diagnosed by the doctor when one or more of the following is/are present:
    - Gingivitis is present of many teeth
    - Calculus is visibly present above and/or below the gumline
    - Probing depths of 4 mm or greater
    - Radiographic bone loss is present on some or all teeth
    - Radiographic calculus
    - Bleeding when probing

***Cleanings may be completed at first visit IF time permitting.**

The goals of dental cleanings are to eliminate any further damage to the periodontium (bone, gums, ligaments) that supports the teeth, prevent tooth loss, eliminate harmful toxins/bacteria, remove infection, eliminate bad breath, and restore overall oral and systemic health.

Patient Name: _____

Patient Signature: _____ Date: _____

# HIPAA Consent Form

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I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third-party payers (e.g., my insurance company)
- The day-to-day healthcare operations of your practice

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and this I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and healthcare operations, but you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

_____

**Authorization To Disclose Protected Health Information**

I authorize the following to disclose my protected health information:

Fresh Dental Family Dentistry and Implant Center
16631 Coit Rd, Suite #114
Dallas, TX 75248
Ph: 214-484-5978 Fax: 214-484-6274

Who Can Receive and Use the Health Information?

Person/Organization Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Patient Name: _____

Patient Signature: _____ Date: _____

# Dental Radiographs (X-rays)

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## Dental X-rays: An Overview

Everyone's oral health is different, and a visual examination is not enough to tell the dentist everything they need to know during your visit. X-rays, or radiographs, are just as important as regular cleanings to allow the dentist to see between the teeth, inside the teeth, and the roots of the teeth, and the bone around the teeth to check for any hidden problems not visible to the naked eye. This allows us to detect any issues that may not be causing you pain.

The US Federal Drug Administration (FDA) and the American Dental Association (ADA) have set guidelines and regulations for what x-rays to take and how frequently they can be taken. New patients require more x-rays to ensure their mouths are healthy, but as you continue your regular checkups, fewer x-rays are needed at your next visits.

## Dental X-rays: Types of X-rays

### Extra-oral Radiographs

These x-rays focus on the jaw and skull. Although the dentist can see the teeth, these x-rays are used to detect cysts, abscesses, masses, and impacted teeth, as well as any problems with the bones in the face, sinuses, temporomandibular joint (TMJ), or jaw joint.

Types of extra-oral x-rays that we may take in our office:

PANORAMIC: shows the entire mouth area. Useful for seeing the position of teeth, detecting impacted teeth and aid in the diagnosis of tumors.

CEPHALOMETRIC: shows the entire side of the head. Used to examine the relationship of the teeth to the jaw and patient's profile. Helps to create an orthodontic treatment plan.

### Intra-oral Radiographs

These are the most common types of x-rays taken in the dental office. These are smaller, detailed x-rays that allow the dentist to check for cavities, see under the edge of fillings and/or crowns, and check the health of the none and roots of teeth.

Types of intra-oral x-rays that we may take in our office:

BITEWINGS: shows the entire tooth and bone below the root. Useful in detecting abnormalities of the roots or bone anchoring a tooth to the jaw.

Dental X-rays – Radiation

Modern techniques and equipment allow dental offices to minimize the radiation exposure from dental x-rays to almost negligible amounts. This allows us to safely take x-rays on both adults and children. However, to protect you from the low levels of radiation emitted from x-rays, our office uses a lead apron to prevent radiation exposure to your vital organs.

Patient Name: _____

Patient Signature: _____ Date: _____

**To see how the amount of radiation from dental x-rays compares to other sources, please see the chart on the back of this page.**

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| All Radiation Doses are in millisieverts (mSV) | | |
|---|---|---|
| | 0.00005 | Sleeping next to someone, for 1 year |
| | 0.00010 | Eating 1 banana |
| | 0.00025 | Airport security body scanner |
| | **0.00500** | **1 Bitewing or Periapical dental x-ray** |
| | **0.01000** | **1 Panoramic dental x-ray** |
| | 0.04000 | Flight from New York to Los Angeles |
| | 0.07000 | Living in a brick/stone/concrete house for 1 year |
| | 0.10000 | Chest x-ray |
| | 0.40000 | Eating food for 1 year |
| | 0.42000 | Mammogram |
| | 12.00000 | Full body CAT scan |
| | 36.0000 | Smoking 1.5 packs of cigarettes everyday for 1 year |
| | 80.0000 | 6 months on the international space station |

*Data obtained from the American Dental Association, International Atomic Energy Association, National Aeronautics & Space Association*

**Please inform our office staff if you are pregnant or think you may be pregnant before we take x-rays.**

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## Acknowledgement of Notification Security Camera Use

To protect the safety of our employees and patients, area(s) of our facility are monitored and recorded via video surveillance 24 hours a day, seven days a week. There is a live, real-time video feed located in these areas to aid in the investigation process of an accident/near miss situation or for any quality issues that may occur. Only the authorized personnel have on-site access to previously recorded footage. All information and/or observations made in the use of security cameras are considered confidential and can only be used for official and law enforcement purposes.

Private areas such as restrooms will never be under surveillance or recorded.

## Website Consent Form

Authorization: **For use or disclosure of patient photograph and/or video images release form:**

Our office occasionally posts in-office photos and videos to our website and social media accounts for educational, illustrative or marketing purposes. If you would or would not like to participate, please let us know by indicating your choice below. Your image will never be used without your consent, and you may revoke consent by submitting a simple written and signed request at any time.

Purpose: **The photographic/video images, and/or testimonial will be used for: Social Media and/or Advertising**

I grant Fresh Dental and its representatives and associates the right to use my image and likeness for informative, educational, illustrative, or marketing purposes in print or electronically, including but not limited to their website and social media accounts.

I understand that my image and likeness will not be used for any other commercial purposes, and that Fresh Dental will make all reasonable efforts to safeguard my privacy as required by applicable law, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand, however, that Fresh Dental cannot guarantee my complete privacy in the event my image or likeness is used by a third party.

Revocability: I understand that I may revoke this authorization at any time, but such revocation must be in writing and received by the practice via registered mail or in person. Revocation affects disclosure moving forward and is not retroactive. This authorization expires 99 years from date signed.

No Treatment Conditions: I understand that the practice cannot condition treatment on whether I sign this authorization.

▢ Check if you DO NOT ALLOW Fresh Dental to use any of my x-rays or before and after pictures for marketing/educational purposes.

Patient Name: _____

Patient Signature: _____ Date: _____

# Financial Agreement

Fresh Dental
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PAYMENT IS DUE AT THE TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE

It is our policy to have a definite agreement between you, the patient, and this office concerning the payment of the fees for services rendered. If you have any questions regarding the cost of your treatment, please ask our front desk for an approximate cost prior to treatment. For convenience, we accept cash, American Express, VISA, Master Card, Discover, and Care Credit. All emergency dental services or any dental service performed without previous financial arrangements with the office manager must be paid for at the time of service.

PATIENTS NOT COVERED BY DENTAL INSURANCE

Payment is expected when services are rendered. If major dental work is required, it is understood that at least half of the balance will be paid when treatment is started. The remaining balance is due when the treatment is completed. Financial responsibility on the part of each patient will be determined before treatment. Any dental service performed without previous financial arrangement or verified dental insurance must be paid for at the time of service.

PATIENTS COVERED BY DENTAL INSURANCE OR IN OFFICE DENTAL PLAN

If you have dental insurance, we will be happy to complete the necessary forms for your claim as a courtesy to you. However, your insurance is a contract between you and your insurance company. You are responsible for your entire bill regardless of what your insurance company pays. We are a third party providing the service to you. We require that you be responsible for your copayment and deductible at the time of service. After insurance has been filed and if benefits have not been received within 60 days from your insurance company, the entire balance becomes the patient's responsibility. A refund will be given when the benefits have been received from the insurance company. The office cannot render service on the assumption your charges will be paid by your insurance company. Any balance exceeding 60 days may have a 10% per annum service charge on the unpaid balance. We charge a $35 billing fee for any statement sent 90 days after charges were incurred.

# APPOINTMENT CONFIRMATION AGREEMENT

**To hold your appointment time, we require confirmation.** Unless a call is requested, we confirm appointments through an automated text. Patients will be texted 3 days prior to their appointments to reply 'YES' to confirm. If patients do not reply 'YES' or indicate that they wish to reschedule/cancel, they will be given a courtesy call the day prior to their appointment to confirm. If not confirmed by 5 pm the day prior to your appointment, you will be removed from the schedule to allow for another patient to take that time. **If you confirm an appointment but do not show, we will charge a $50 fee for each missed appointment (This includes canceling the day of appointment)**. If you come to your appointment without confirming, we will try our best to accommodate you, but we cannot guarantee treatment.

Saturday availability is by appointment only and treatment will need to be paid upfront when scheduled OR the Monday prior. Patients who cancel twice for their Saturday appointment will no longer be able to schedule for this day in the future.

**I have read and understand the above Financial and Appointment Confirmation Agreements.**

Patient Name: _____

Patient Signature: _____ Date: _____