FAMILY DENTISTRY

Greg J. Frei, DDS

Patient Registration

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

Address: _____
Street Apt# City State Zip Code

Home Phone: _____ Cell Phone: _____ Email: _____

Whom may we thank for referring you to our practice?

☐ Another patient ☐ Another office ☐ School ☐ Sign ☐ Internet ☐ Other _____

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

Responsible Party Information

Name: _____ Relationship to Patient: _____
First MI Last

Address: _____
Street Apt# City State Zip Code

Birth Date: _____ SSN#: _____ Home Phone: _____ Cell Phone: _____

Email: _____ Employer: _____ Work Phone: _____

Spouse's Name: _____ Contact Phone: _____

Emergency Contact / Relationship _____ Contact Phone: _____

Insurance Information

☐ Employer Group Policy ☐ Self Insured

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

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

Home Phone: _____ Cell Phone: _____ Email: _____

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

Policy Holder's Employer: _____ Policy Holder's Employer's Phone Number: _____

Dental Insurance: _____ ID#: _____ Grp#: _____

Insurance Address / Phone: _____

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, or Parent/Guardian **Date**

Medical History

Patient Name: _____
Date of Birth: _____

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?	Y / N	If yes_____
Have you ever been hospitalized or had a major operation?	Y / N	If yes_____
Have you ever had a serious head or neck injury?	Y / N	If yes_____
Are you taking any medication, pills or drugs?	Y / N	If yes_____
Do you take or have you taken Phen-Fen or Redux?	Y / N	If yes_____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Y / N	If yes_____
Are you on a special diet?	Y / N	If yes_____
Do you use tobacco?	Y / N	If yes_____

Women:	Are you pregnant / trying to get pregnant?	Y / N	If yes_____
	Are you nursing?	Y / N	
	Are you taking oral contraceptives?	Y / N	If yes_____

Are you allergic to any of the following: (circle any that apply)

Aspirin	Penicillin	Codeine	Acrylic
Metal	Latex	Sulfa drugs	Local anesthetics

Other?	Y / N	If yes _____
Do you use controlled substances?	Y / N	If Yes _____

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

AIDS/HIV Positive	Y/N	Cortisone Medicine	Y/N	Hemophilia	Y/N	Radiation Trmts	Y/N
Alzheimer's Disease	Y/N	Diabetes	Y/N	Hepatitis A	Y/N	Recent Weight Loss	Y/N
Anaphylaxis	Y/N	Drug Addiction	Y/N	Hepatitis B/C	Y/N	Renal Dialysis	Y/N
Anemia	Y/N	Easily Winded	Y/N	Herpes	Y/N	Rheumatic Fever	Y/N
Angina	Y/N	Emphysema	Y/N	High Blood Pressure	Y/N	Rheumatism	Y/N
Arthritis/Gout	Y/N	Epilepsy/Seizures	Y/N	High Cholesterol	Y/N	Acid Reflux	Y/N
Artificial Heart Valve	Y/N	Excessive Bleeding	Y/N	Hives or Rash	Y/N	Shingles	Y/N
Artificial Joint	Y/N	Excessive Thirst	Y/N	Hypoglycemia	Y/N	Sickle Cell Disease	Y/N
Asthma	Y/N	Fainting/Dizziness	Y/N	Irregular Heartbeat	Y/N	Sinus Trouble	Y/N
Blood Disease	Y/N	Frequent Cough	Y/N	Kidney Problems	Y/N	Spina Bifida	Y/N
Blood Transfusion	Y/N	Frequent Diarrhea	Y/N	Leukemia	Y/N	Stomach/Intestinal Disease	Y/N
Breathing Problems	Y/N	Frequent Headaches	Y/N	Liver Disease	Y/N	Stroke	Y/N
Bruise Easily	Y/N	Genital Herpes	Y/N	Low Blood Pressure	Y/N	Swelling of Limbs	Y/N
Cancer	Y/N	Glaucoma	Y/N	Lung Disease	Y/N	Thyroid Disease	Y/N
Chemotherapy	Y/N	Hay Fever	Y/N	Mitral Valve Prolapse	Y/N	Tonsillitis	Y/N
Chest Pains	Y/N	Heart Attack/Failure	Y/N	Osteoporosis	Y/N	Tuberculosis	Y/N
Cold Sores/Fever Blisters	Y/N	Heart Murmur	Y/N	Pain in Jaw Joints	Y/N	Tumors/Growths	Y/N
Congenital Heart Disorder	Y/N	Heart Pacemaker	Y/N	Parathyroid Disease	Y/N	Ulcers	Y/N
Convulsions	Y/N	Heart Trouble/Disease	Y/N	Psychiatric Care	Y/N	Venereal Disease	Y/N

Have you ever had any serious illness not listed? **Y / N** **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, or Parent/Guardian **Date**

Gregory J Frei, DDS

22101 State Hwy 46 West
Spring Branch, TX 78070
Phone: 830-438-2273

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 any misunderstandings. Please read and initial each line before adding your signature.

_____**APPOINTMENTS:** We ask that you arrive 10 minutes early to update necessary medical history forms. If you have moved, changed your phone number or changed 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: $50** Cancellation will be applied to missed or canceled appointments without **24 hour notice**

_____ **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. We accept MasterCard, Visa, Discover & American Express for all credit card payments.

_____ **INSURANCE:** All levels of payment by insurance companies, including allowed fees, usual and customary fees, 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 of 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 90 days delinquent, it may be placed in collections and there will be an additional 30% processing fee added to your balance. 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 ultimately your responsibility to understand your benefits. If you have any questions regarding your 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 will 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

_____

Signature of Patient, or Parent/Guardian ***Date***

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/FACILITIES IN THE FUTURE.

_____ _____

Please print name of Patient | Signature of Patient, or Parent/Guardian

_____ _____

If Parent/Guardian, please print your name | Relationship of Parent/Guardian

Your comments regarding Acknowledgements or Consents: _____

_____

How do you want to be addressed when summoned from the reception area:
☐ First Name Only ☐ Proper Surname ☐ Other _____

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, and billing information** via:

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

I authorize **information about my health** be conveyed via:

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

I approve being contacted about **special services, events, fund raising efforts or new health info** on behalf of this healthcare facility via:

☐ Cell Phone Confirmation _____
☐ Home Phone Confirmation _____
☐ Text Message to my Cell Phone _____
☐ Email confirmation _____
☐ Any of the Above
☐ None of the Above (opt out)

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