REVEAL DENTAL
COSMETIC, FAMILY & IMPLANT DENTISTRY

PRINT

PATIENT REGISTRATION AND HISTORY

Today's Date: _____

Patient's Name _____ DOB: _____ Sex: ☐Male ☐Female

If a Child, Parent's Name: _____ Preferred Name/Nickname: _____

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

Home Phone #: _____ Cell #: _____ Work #: _____

Email: _____ Preferred method of contact: ☐Home ☐Cell ☐Work ☐Email

Marital Status: ☐Single ☐Married Spouse's Name: _____ ☐Widowed ☐Divorced

Referred by: _____ Nearest Relative Not Living With You: _____

Person Financially Responsible: _____ Relationship to Patient: _____

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

Patient's/Parent's Occupation: _____ Employer: _____

Employer's Address: _____ City: _____ State: _____ Zip: _____

Spouse's Occupation: _____ Employer: _____

Emergency Contact: _____ Emergency Contact Phone: _____

Primary Dental Insurance:

Employee Name: _____ Insurance Company: _____

Ins. Phone #: _____ Group #: _____

Policy #: _____ SS#: _____ DOB: _____

Secondary Dental Insurance:

Employee Name: _____ Insurance Company: _____

Ins. Phone #: _____ Group #: _____

Policy #: _____ SS#: _____ DOB: _____

Please indicate with a (✓) to ***OPT IN*** for choice of appointment confirmations:

☐EMAIL ☐TEXT MESSAGES ☐PHONE CALLS

MEDICAL HISTORY

PLEASE ANSWER ALL QUESTIONS WITH A YES OR NO *INDICATE WITH A (✓)*

Patient's Physician: _____ Address: _____

YES/NO

- ☐ ☐ List any known drug allergies to drugs or anesthetics: _____ _____
- ☐ ☐ List any heart ailments: _____
- ☐ ☐ Antibiotic Prophylaxis Prior to Dental Treatment?
- ☐ ☐ Artificial replacements such as hip, knee, heart, etc. (Include Dates) _____ _____
- ☐ ☐ Have you ever taken prescription medication for weight reduction?
  If "**YES**," did you take any of the drugs (**diet pills**) listed below?
  - ☐ **Fen-Phen (fenfluramine + phentermine)**
  - ☐ **Pondimin (fenfluramine)**
  - ☐ **Redux (dexfenfluramine)**
- ☐ ☐ **Pregnancy or Nursing (if so, _____months.)**
- ☐ ☐ **Latex Allergy**
- ☐ ☐ Abnormal Bleeding
- ☐ ☐ Alcohol Abuse
- ☐ ☐ Allergies
- ☐ ☐ Anemia
- ☐ ☐ Angina Pectoris
- ☐ ☐ Arthritis
- ☐ ☐ Artificial Bones
- ☐ ☐ Attention Deficit Disorder/ADHD
- ☐ ☐ Asthma
- ☐ ☐ Birth Control Specify:_____
- ☐ ☐ Blood Transfusion
- ☐ ☐ Cancer - Type and Date: _____
- ☐ ☐ Colitis
- ☐ ☐ Congenital Heart Failure
- ☐ ☐ Cosmetic Surgery
- ☐ ☐ Diabetes
- ☐ ☐ Difficulty Breathing
- ☐ ☐ Eating Disorders
- ☐ ☐ Epilepsy
- ☐ ☐ Fainting Spells
- ☐ ☐ Frequent Headache
- ☐ ☐ Hay Fever or other allergies
- ☐ ☐ Heart Surgery
  List Type:_____
  Date:_____
- ☐ ☐ Hemophilia
- ☐ ☐ Hepatitis (A) (B) (C)
- ☐ ☐ High Blood Pressure
- ☐ ☐ High Cholesterol
- ☐ ☐ Kidney Problems
- ☐ ☐ Liver Disease
- ☐ ☐ Mitral Valve Prolapse
- ☐ ☐ Neurological Problems
- ☐ ☐ Night Sweats
- ☐ ☐ Pace Maker - Year Placed: _____
- ☐ ☐ Pneumocystis
- ☐ ☐ Psychiatric Problems
- ☐ ☐ Radiation Therapy
- ☐ ☐ Recreational Drug Usage/Marijuana/CBD
- ☐ ☐ Rheumatic Fever
- ☐ ☐ Seizures
- ☐ ☐ Shingles
- ☐ ☐ Sinus Problems
- ☐ ☐ Stroke - Date: _____
- ☐ ☐ Thyroid Problems
- ☐ ☐ Tuberculosis
- ☐ ☐ Other: _____

Please list any other conditions not listed above: _____

Please list any medications you are currently taking: _____

_____

DENTAL HISTORY

CHIEF ORAL COMPLAINT: _____ DATE OF LAST DENTAL EXAM: _____

HAVE HAD ANY MAJOR DENTAL TREATMENT? If SO, WHEN: _____WHAT WAS DONE? _____

DO YOU HAVE OR DO YOU USE ANY OF THE FOLLOWING? INDICATE WITH A (✓)

- ☐ Sensitivity to Hot/Cold, Sweets or Pressure
- ☐ Bleeding Gums, How long?
- ☐ Food Impaction
- ☐ Clenching or Grinding
- ☐ Burning of Tongue
- ☐ Swelling or Lumps in Mouth
- ☐ Frequent Blisters on Lips or in Mouth
- ☐ Pain around the Ear
- ☐ Dental Floss, How often? _____
- ☐ Dry Mouth
- ☐ Bad Breath
- ☐ Unfavorable Dental Experience
- ☐ Complications from Extractions
- ☐ Periodontal Treatment
- ☐ Orthodontic Treatment
- ☐ Mouth Breathing or Snoring
- ☐ Mouth/ Night Guard
- ☐ Frequency of Brushing #: _____
- ☐ Oral Habits i.e.: Fingernail biting, Gag reflexes
- ☐ Would you like to discuss improving the appearance of your teeth and/or smile?
- ☐ Unpleasant taste
- ☐ Inter Dental Stimulators
- ☐ Retainers/Removable Appliances
- ☐ Dentures/Partial Dentures
- ☐ Fluoride Supplements
- ☐ Teeth Whitening Products
- ☐ Sleep Devices/CPAP
- ☐ Cigarette, pipe or Vape/e-cigs
- ☐ Teeth Implants

Please write anything you feel will be helpful in allowing us to personalize your care: _____

INSURANCE: Our goal is to help maximize your dental insurance benefits. As a courtesy, we are happy to bill your dental plan for services. When we call on your insurance and verify benefits it is not a guarantee of payment by the insurance company and may vary according to your individual plan when the actual claim is submitted. Any treatment plan that our office proposes to you is an estimate of what your insurance coverage will be; it is not a guarantee. If you need exact payment of benefits, then a predetermination is required by patient request. If you would like this done, you must specify to the office administrator ***before*** any work is initiated.

All accounts are due in full upon receipt of your statement, regardless of insurance. Interest may be charged on delinquent accounts.

Please note that cancellation or failing to appear to an appointment **with less than a 48 hours' notice** will result in a charge for that visit. This charge must be settled prior to making a new appointment.

_____ _____

Print Patient's Name Date

_____

Patient Signature
(Parent/Guardian, if patient is a minor)

_____ _____

Alkesh C. Sura, DDS Date

REVEAL DENTAL
COSMETIC, FAMILY & IMPLANT DENTISTRY

Alkesh C. Sura, DDS PA
1785 E. Whitestone Blvd, Suite 400
Cedar Park, TX 78613
512.337.2316

Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations, we must require you to read and sign this consent form stating that you understand and agree with how your records will be used.

If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the **HIPAA NOTICE** that is available to you at the front desk before signing this consent.

- The patient understands and agrees to allow Reveal Dental to use their PHI for the purpose of treatment, payment, healthcare operations, and coordination of care with specialists. As an example, the patient agrees to allow Reveal Dental to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for the requirements of these insurance companies.
- The patient has the right to examine and obtain a copy of his/her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
- A patient's written consent need only be obtained one time for all subsequent care given to the patient in this office.
- The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request hast been presented.
- For your security and right to privacy, all staff has been trained in the area of patient record privacy. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
- Patients have the right to file a formal complaint with our office about any possible violations of these policies and procedures.
- If the patient refuses to sign this consent for the purpose of treatment, payment and healthcare operations, Reveal Dental has the right to refuse care.

I have read and understand how my Patient health Information will be used and I agree to these policies and procedures.

Name _____ Signature _____

Date _____

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FINANCIAL RESPONSIBILITY FORM

As our dedication to service and a courtesy to you, we will assist you in filing your insurance claims to help you obtain your benefits. In order for our office to file your insurance claims, you must bring proof of insurance, and then we can estimate your payment allowing you to settle your account at time of service. It is very important that the correct insurance information is provided at the time of the patient's appointment. If this information changes, it is the patient's responsibility to update Reveal Dental at the earliest convenience. While we do our best to verify dental benefits prior to your first appointment, this does not guarantee coverage or payments to Reveal Dental.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services regardless of dental insurance. Dental insurance is a benefit for the patient provided by their employer and the contract lies between the patient, employer and the insurance company. Our office is not a party to that contract.

Payment is due at the time service is provided. We accept cash, checks, Visa, MasterCard, American Express and Care Credit. Returned checks will be subject to additional fees.

We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. However, this office will not enter into a dispute with your insurance company over any claim. Once insurance has paid their share, a statement will be sent to you for any remaining balance and will be due upon receipt. If your insurance company has not made payment within 60 days, the unpaid balance becomes your responsibility and is subject to finance charges and the collection process.

***Separated & Divorced Couples with Dependent Children*:** It is the policy of this office to bill the parent that brings the children in for their dental treatment. Please make arrangements for payment from an ex-spouse before dental treatment is rendered. We can provide a treatment cost estimate before your scheduled appointment.

Cancellation & Late Policy: Your appointment time is reserved for you. For cancellation we require 48 hours advanced notice or a charge will be made. An answering machine is available for messages left after business hours.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our policies. Significant costs are incurred in carrying our patients' accounts. To control these costs and help keep fees down, it is necessary to adhere to these policies.

I acknowledge having read this Financial Responsibility Form in its entirety and agreed to be bound by all terms and conditions herein.

NAME (Print)

SIGNATURE

DATE