REGISTRATION AND HEALTH HISTORY

Round Rock Family Dental
2000 IH 35 S, Suite K-1
Round Rock, TX 78681
512-255-7839

NAME ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED

NAME OF SPOUSE (PARENT, IF A MINOR) HOME PHONE CELL PHONE SOCIAL SECURITY NO.

RESIDENCE ADDRESS CITY STATE ZIP CODE

MAILING ADDRESS (IF DIFFERENT FROM ABOVE) DRIVER'S LICENSE NUMBER (PARENT, IF A MINOR)

EMPLOYEE CITY STATE WORK PHONE

SPOUSE EMPLOYEE CITY STATE WORK PHONE

HOW DID YOU FIND OUT ABOUT OUR OFFICE?

WHO WILL PAY FOR THIS ACCOUNT? METHOD OF PAYMENT: ☐ CASH ☐ CHECK ☐ CREDIT CARD

NAME OF DENTAL INSURANCE COMPANY GROUP PLAN NO. NAME & SOCIAL SECURITY NO. OF INSURED DATE OF BIRTH

MEDICAL HISTORY

PHYSICIAN'S NAME_____ DATE OF LAST PHYSICAL EXAM_____

BIRTHDATE_____ AGE_____ IN CASE OF EMERGENCY NOTIFY:_____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

☐ Any heart problems
☐ High Blood Pressure
☐ Low Blood Pressure
☐ Circulatory problems
☐ Nervous problems
☐ Radiation treatments
☐ Excessive bleeding
☐ Are you pregnant?
☐ Allergies to anesthetics
☐ Allergies to medicines or drugs – list below
☐ Heart Murmur
☐ Anemia
☐ Arthritis
☐ Asthma
☐ Birth Control Pills
☐ Diabetes
☐ Hepatitis
☐ Malignancies
☐ Measles
☐ Mumps
☐ Psychiatric care
☐ Rheumatic Fever
☐ HIV
☐ Scarlet Fever
☐ Sinus Problems
☐ Stroke
☐ Typhoid Fever
☐ Tonsillitis
☐ Tuberculosis
☐ Ulcer

☐ Have you ever had an Organ Transplant or Joint Replacement? If yes, please list: _____

☐ Are you currently on or have you ever been given medication for Osteoporosis (Bisphosphonate such as Fosamax or a generic form)?

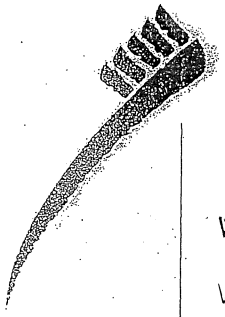
Please describe any current medical treatment, impending operations, or any other medical or dental information that may possibly affect your dental treatment. _____

Please list any current medications you are taking, including vitamins and natural supplements. _____

Please list any drug allergies. _____

Please list your chief dental concerns. _____

DATE _____ SIGNATURE _____



ROUND ROCK FAMILY DENTAL

Welcome to our office

We are pleased to have you as a patient and look forward to working with you in restoring and maintaining your dental health. As a new patient, we would like to briefly review the policies of our office.

Payment is due at the time services are rendered. Please understand that we are not a financial institution and offer no payment plans. We accept cash, personal checks, MasterCard, Visa, Discover and American Express cards. **As a courtesy to our patients,** we will accept insurance assignment when all pertinent information is provided and verification of coverage has been established. Diagnosis and treatment recommendations are made according to your individual needs and not in accordance with what your insurance policy will or will not cover. While the filing of insurance claims is a courtesy that we provide, payment for services remains the sole responsibility of the patient.

If you desire our office to accept insurance assignment, we require that your deductible and any co-payment be made at the time of your visit. We will do our best to estimate what charges will be covered by your insurance, but understand it is impossible for us to know the details of each individual policy. These estimates do not include charges for services performed outside our office such as lab fees, which are billed separately and may or may not be covered by your insurance. This office quotes current fees that are within the usual and customary range of dental offices in our area. Many insurance companies pay from a set fee schedule that is often outdated.

Once payment is received from your insurance, you will be sent a statement for any balance on your account. It is important to recognize that your insurance policy is an agreement between you, your employer and the insurance company. We are not a party to that agreement and your benefit assignment does not take the place of your responsibility to pay for services rendered. Charges that are not covered by your insurance company are the responsibility of the patient. Any dispute concerning coverage will be between you and your insurance company. **Balances that remain unpaid will incur a $5.00 per month service charge.** _____ Personal checks returned to our office unpaid will incur a $25.00 returned check charge.

The treatment room will be reserved specifically for you during your appointment time. **Failure to keep your appointment or to give a 24 hour cancellation notice will result in a $25.00 cancellation fee.** _____. **This fee will not be waived.** In cases of divorced parents, the parent bringing the child to the initial visit will be deemed responsible for payment. Our office will not become involved in custody disputes regarding which parent is the responsible billing party.

If you should have any questions regarding your bill or your treatment, please feel free to consult the office manager. Communication is important for us to keep you comfortable and happy with our services.

I have read the above and understand that I am responsible for all office charges. I also understand that once payment or notice of non-payment has been received from my insurance company, and balance remaining on my account will be due within 30 days.

_____ _____

Signature of responsible party **Date**

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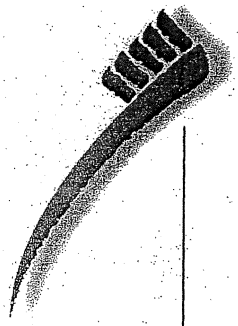

ROUND ROCK FAMILY DENTAL

Acknowledgement of Receipt
Round Rock Family Dental
Notice of Privacy Practices

I, _____ have received a copy of
(Name of patient)
Round Rock Family Dental's **Notice of Privacy Practices**.

_____
Signature of Patient/Parent or Guardian

_____
Date

Staff Will Fill Out This Section If Patient's Signature Not Obtained

Our office made a good faith effort to obtain Acknowledgement of Receipt of our Notice of Privacy Practices, but it could not be obtained for the following reasons:

____ Patient refused to sign.
_____ Emergency situation kept us from obtaining the patient's signature.
_____ Language barriers kept us from obtaining the patient's signature.
_____ Other: _____

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