



Thank you for choosing My Hometown Dentist of Leon Springs for your dental needs. We are committed to providing you with excellent care, unprecedented convenience, and affordable financial options. Our financial arrangements are based on an open and honest discussion of recommended treatment options, respective fees and patients' financial capabilities.

To confirm your understanding and agreement with our policies, please read and sign the following.

Payment:

Payment is due in full when scheduling dental treatment. For your convenience we offer several payment options.

- Cash, Visa, MasterCard, American Express, and Discover
- Checks
- Extended payment plans provided through Care Credit and other finance companies

Insurance:

Our office is committed to helping patients maximize their benefits, however insurance policies vary greatly. Therefore, we can only ESTIMATE in good faith, not guarantee payment or coverage from your insurance carrier. Any and all estimated out-of-pocket expenses will be discussed in detail before starting any dental procedures.

Financial Consent:

The patient or guardian agrees to be fully responsible for total payment of treatment performed in this office regardless of reimbursement from Insurance carrier.

I understand and agree to this Financial Policy and Agreement. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize My Hometown Dentist and their Associate Doctors to release any information required to process my claims.

Name of Patient (Please Print)

Name of Responsible Party (Please Print)

Signature of Responsible Party

Date

PATIENT REGISTRATION FORM

Today's Date: _____

PATIENT INFORMATION

| | | | |
|--|------------------------------------|---------|---|
| Last Name: | First: | Middle: | Preferred Name: |
| <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. | Marital Status (please circle one) | | Birth Date: _____ / _____ / _____ |
| <input type="checkbox"/> Ms. | Single / Married / Other : _____ | | Social Security Number: _____ - _____ - _____ |

| | |
|-----------------------------|--|
| Email Address: _____ | Cell Phone Number: () _____ |
|-----------------------------|--|

| | | | | |
|--|---------------------------------|---|---------------------------------------|---|
| Address: | City: | State: | Zip code: | Home Phone Number: () _____ |
| Occupation: | Employer: | | | Employer Phone Number: () _____ |
| Chose clinic because/Referred to clinic by (please check one box): | | | <input type="checkbox"/> Dr. | <input type="checkbox"/> Insurance Plan <input type="checkbox"/> Hospital |
| <input type="checkbox"/> Family | <input type="checkbox"/> Friend | <input type="checkbox"/> Close to home/work | <input type="checkbox"/> Yellow Pages | <input type="checkbox"/> Other |

Other family members seen here: _____

| | |
|---|--|
| <p>Medical History</p> <p>Are you under a physician's care now? <input type="radio"/> No <input type="radio"/> Yes</p> <p>Have you ever been hospitalized or had a major operation? <input type="radio"/> No <input type="radio"/> Yes</p> <p>Have you ever had a serious head or neck injury? <input type="radio"/> No <input type="radio"/> Yes</p> <p>Are you on a special diet? <input type="radio"/> No <input type="radio"/> Yes</p> <p>Do you use tobacco? <input type="radio"/> No <input type="radio"/> Yes</p> <p>List Medications: _____</p> <p>_____</p> | <p>Women Only:</p> <p>Are you... <input type="checkbox"/> Pregnant Do you get sleepy though out the day? ___ Yes ___ No</p> <p> <input type="checkbox"/> Trying to get Pregnant</p> <p> <input type="checkbox"/> Nursing Do you snore? ___ Yes ___ No</p> <p> <input type="checkbox"/> Taking Oral Contraceptives?</p> <p>Have you ever had a sleep study or been prescribed a CPAP? ___ Yes ___ No</p> |
| <p><u>Are you allergic to any of the following?</u></p> <p><input type="radio"/> Aspirin <input type="radio"/> Penicillin <input type="radio"/> Codeine <input type="radio"/> Acrylic <input type="radio"/> Metal <input type="radio"/> Latex <input type="radio"/> Local Anesthetics <input type="radio"/> Other _____</p> | |

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

- | | | | |
|---|---|---|---|
| <input type="radio"/> AIDS/HIV Positive | <input type="radio"/> Drug Addiction | <input type="radio"/> Headaches | <input type="radio"/> Scarlet Fever |
| <input type="radio"/> Alzheimer's Disease | <input type="radio"/> Epilepsy or Seizures | <input type="radio"/> Heart Condition _____ | <input type="radio"/> Shingles |
| <input type="radio"/> Arthritis/Gout | <input type="radio"/> Excessive Thirst | <input type="radio"/> Kidney Problems | <input type="radio"/> Stomach/Intestinal Disease |
| <input type="radio"/> Artificial Joint | <input type="radio"/> Fainting Spells/Dizziness | <input type="radio"/> Liver Disease | <input type="radio"/> Sinus Trouble |
| <input type="radio"/> Asthma | <input type="radio"/> Glaucoma | <input type="radio"/> Lung Disease | <input type="radio"/> Tumor or Growths |
| <input type="radio"/> Cancer | <input type="radio"/> Hemophilia | <input type="radio"/> Pain in Jaw Joints | <input type="radio"/> Parathyroid / Thyroid Disease |
| <input type="radio"/> Cold Sores/Fever Blisters | <input type="radio"/> Hepatitis _____ | <input type="radio"/> Psychiatric Care | |
| <input type="radio"/> Diabetes | <input type="radio"/> High or Low Blood | <input type="radio"/> Stroke | |

Have you ever had any serious illness not listed above? Yes No N/A _____

In case of Emergency:

| | | |
|--|--------------------------------|---|
| Name of Local Friend or Relative (not living in same address): _____ | Relationship To Patient: _____ | Good Phone Number: _____ () _____ |
|--|--------------------------------|---|

The above information is true to the best of my knowledge.

Patient / Guardian Signature: _____ **Date:** _____

HIPAA Information and Consent

I acknowledge that I have read or have had the opportunity to read My Hometown Dentist HIPAA Information Policy. I have also had the opportunity to ask questions about it and understand that I may receive a copy of this at my request. By signing below, I understand how my Patient Health Information will be used and I agree to these policies and procedures.

Signed: _____ **Date:** _____