MOMENT DENTAL

581 University Blvd., Ste 400
Round Rock, TX 78665
info@momentdental.com | (512) 244-3333

Confidential Patient Registration

Today's Date: _____

Patient Name: _____ Date of Birth: _____

Responsible Party's Name: _____ Relationship to Patient: _____
(if not the patient):

Street Address:_____

City/State/Zip Code: _____ SSN #: _____

Marital Status: □ Single □ Married □ Divorced □ Separated □ Widowed

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-mail: _____

Pharmacy Name: _____ Pharmacy Phone #: _____

Whom may we thank for referring you?

_____

Insurance Information

Primary Policy Holder's Name: _____

Policy Holder's DOB: _____ Policy Holder's SSN: _____

Relationship to Patient: _____ Policy Holder's Employer: _____

Insurance Company: _____ Phone Number: _____

Group Number: _____ ID Number: _____

Secondary Primary Policy Holder's Name:

_____

Policy Holder's DOB: _____ Policy Holder's SSN: _____

Relationship to Patient: _____ Policy Holder's Employer: _____

Insurance Company: _____ Phone Number: _____

Group Number: _____ ID Number: _____

MOMENT DENTAL
581 University Blvd., Ste 400
Round Rock, TX 78665
info@momentdental.com | (512) 244-3333

Confidential Medical History

Today's Date: _____

Patient's Name (First, MI, Last) _____ Date of Birth: _____

Physician Name: _____ Phone #: _____ Date of last Exam:_____

Are you currently under a physician care? If YES, please explain: _____

Have you had any serious illnesses, operations, or been hospitalized ? If YES, please explain: _____

Are you taking or have you taken Phen-Fen/Redux? ☐ YES ☐ NO

Are you taking or have you taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ YES ☐ NO

Please list all medications you are currently taking: _____

Are you allergic to any of the following (leave blank if none):

☐ Aspirin ☐ Barbiturates (Sedatives) ☐ Antibiotics (e.g. Penicillin) ☐ Codeine ☐ Iodine
☐ Latex ☐ Local Anesthetics ☐ Sulfa Drugs ☐ Metals

List all other allergies : _____

Have you had or do you have any of the following? (Please circle YES or NO for each) ☐ YES ☐ NO

AIDS/HIV Positive	☐ YES ☐ NO	Stroke	☐ YES ☐ NO
Glaucoma	☐ YES ☐ NO	COPD/Emphysema	☐ YES ☐ NO
Radiation Treatment	☐ YES ☐ NO	Liver Disease	☐ YES ☐ NO
Alzheimer's Disease	☐ YES ☐ NO	Surgical Implant (s)	☐ YES ☐ NO
Hay Fever/Seasonal Allergies	☐ YES ☐ NO	Cortisone Treatments	☐ YES ☐ NO
Rapid Gain or Weight Loss	☐ YES ☐ NO	Low Blood Pressure	☐ YES ☐ NO
Anemia	☐ YES ☐ NO	Swelling of Limbs	☐ YES ☐ NO
Headache/Migraines	☐ YES ☐ NO	Diabetes Type (1 or 2): _____	☐ YES ☐ NO
Respiratory Disease	☐ YES ☐ NO	Lung Disease	☐ YES ☐ NO
Angina/Chest Pains	☐ YES ☐ NO	Thyroid Disease	☐ YES ☐ NO
Heart Attack/Failure	☐ YES ☐ NO	Drug Addiction	☐ YES ☐ NO
Rheumatic Fever	☐ YES ☐ NO	Mitral Valve Prolapse	☐ YES ☐ NO
Arthrits or Rheumatism	☐ YES ☐ NO	Tonsillitis	☐ YES ☐ NO
Heart Disease	☐ YES ☐ NO	Epilepsy/Seizures	☐ YES ☐ NO
Scarlet Fever	☐ YES ☐ NO	Osteoporosis	☐ YES ☐ NO
Artificial Joints/Replacements	☐ YES ☐ NO	Tuberculosis	☐ YES ☐ NO
Heart Murmur/Irregular Beat	☐ YES ☐ NO	Excessive Thirst	☐ YES ☐ NO
Seizures	☐ YES ☐ NO	Pacemaker	☐ YES ☐ NO
Asthma	☐ YES ☐ NO	Tumors or Growths	☐ YES ☐ NO
Hemophilia	☐ YES ☐ NO	Fainting Spells/Dizziness	☐ YES ☐ NO
Shingles	☐ YES ☐ NO	Pain in Jaw Joints	☐ YES ☐ NO
Back Problems	☐ YES ☐ NO	Ulcers/Colitis	☐ YES ☐ NO
Hepatitis - Type : _____	☐ YES ☐ NO	Frequent Coughs	☐ YES ☐ NO
Sickle Cell Disease	☐ YES ☐ NO	Parathyroid Disease	☐ YES ☐ NO
Bruise Easily/Bleeding	☐ YES ☐ NO	Venereal Disease	☐ YES ☐ NO
Herpes/Cold Sores	☐ YES ☐ NO	Jaundice	☐ YES ☐ NO
Sinus Troubles	☐ YES ☐ NO	Psychiatric Care	☐ YES ☐ NO
Cancer	☐ YES ☐ NO	Leukemia	☐ YES ☐ NO

High Blood Pressure	☐ YES ☐ NO	Congenital Heart Disorders	☐ YES ☐ NO
Skin Rash/Hives	☐ YES ☐ NO	Stomach/ Intestinal Disease	☐ YES ☐ NO
Chemotherapy	☐ YES ☐ NO	Circulatory Problems	☐ YES ☐ NO
High Cholesterol	☐ YES ☐ NO	Kidney or Bladder Disease	☐ YES ☐ NO
Spina Bifida	☐ YES ☐ NO		

Have you had or do you have any of the following? (Please circle YES or NO for each) ☐ YES ☐ NO

Congenital heart disease (CHD) :

Unrepaired, cyanotic CHD	☐ YES ☐ NO	Artificial Heart Valve	☐ YES ☐ NO
Repaired CHD	☐ YES ☐ NO	Previous Infective Endocarditis	☐ YES ☐ NO
Repaired CHD with residual defects	☐ YES ☐ NO	Heart Transplant with damaged valves	☐ YES ☐ NO

Do you have or have any other disease or medical problems NOT listed above If YES, explain.

_____

Pregnant/Trying to get pregnant? ☐ YES ☐ NO Taking oral contraceptives? ☐ YES ☐ NO Nursing? ☐ YES ☐ NO

Dental History

Name of Previous Dentist: _____ Date of last dental exam: _____

Are you happy with the appearance of your teeth/smile? ☐ YES ☐ NO

If NO, please explain: _____

How often do you brush? _____ How often do you floss? _____

Have you ever had any adverse reaction during or in conjunction with a medical or dental procedure? ☐ YES ☐ NO

If YES, please explain: _____

Check if you have had any of the following (leave blank if none):

☐ Bleeding Gums	☐ Difficult extractions in the past	☐ Dental Anxiety/Fear
☐ Grinding/Clenching teeth	☐ Jaw pain/TMJ	☐ Orthodontic Treatment
☐ Prolonged bleeding after extractions	☐ Sensitivity when biting/chewing	☐ Swollen tender gums
☐ Difficulty opening or closing of jaw	☐ Dry Mouth	☐ Denture/Partials
☐ Headaches	☐ Loose/broken teeth or fillings	☐ Periodontal (gum) Treatment
☐ Sensitivity to hot/cold/sweets	☐ Sores or growths in mouth	☐ Other: _____

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

_____ _____

Patient's Signature Date

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

Patient's Signature Date

MOMENT DENTAL
581 University Blvd., Ste 400
Round Rock, TX 78665
info@momentdental.com | (512) 244-3333

Patient HIPAA Consent Form

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 health care providers involved in treatment)
- Obtaining payment from third party payers (e.g. insurance companies)
- The day-to-day healthcare operations of the practice

I have also been informed of and given the right to review and secure a copy of the 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 Moment Dental reserves the right to change the terms of this notice from time to time and that I may contact the practice 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 health care operations. I also understand that I am not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

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 (Printed) Date

_____
Patient/Guardian Signature

I approve releasing my information to the following people:

_____

_____

_____

Assignment and Release

I hereby authorize payment directly to Moment Dental for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges and services rendered to me or my dependents, whether paid or not paid by insurance. I authorize the above doctor(s) and/or provider or supplier of services in this office to release any of my medical or financial information required to secure payment of benefits and to carry out any necessary treatment, payment activities, and health care operations. I authorize the use of this signature on all insurance submissions.

Financial Policy

I understand if I have an unpaid balance to Moment Dental and do not make satisfactory payment arrangements, my account may be placed with an external collection agency. I will be responsible for reimbursement of the fee of any collection agency, which may be based on a percentage at a maximum of 35% of the debt, and all costs and expenses, including reasonable collection and attorney's fees incurred during collection efforts.
In order for Moment Dental or their designated external collection agency to service my account, and where not prohibited by applicable law, I agree that Moment Dental and the designated external collection agency are authorized to (i) contact me by telephone at the telephone number(s) I am providing, including wireless telephone numbers, which could result in charges to me, (ii) contact me by sending text messages (message and data rates may apply) or emails, using any email address I provide and (iii) methods of contact may include using pre-recorded/artificial voice message and/or use of an automatic dialing device, as applicable. Furthermore, I consent the designated external collection agency to share personal contact and account related information with third party vendors to communicate account related information via telephone, text, e-mail, and mail notification.

I also understand that I am billed a $35.00 return check fee for any checks returned for insufficient funds. Payment is due the day of service. Financing is available through Care Credit.

Consent for Use/Disclosure of Health Information

By signing this form you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and health care operations. Your signature also indicates that you have had full opportunity to read and consider our Notice of Privacy Practices, and that you understand that you have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact person listed on that notice. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you and or to continue treating you if you revoke this consent.

Cancellation Policy

As our practice continues to grow, we have updated our cancellation policy in order to better serve our patients. Your appointment time is reserved especially for you. Please give us a call at least 24 hours before your scheduled appointment if you will be unable to keep your appointment. This allows us to offer that appointment to another patient who needs dental care.

If you do not cancel your appointment at least 24 hours in advance, you will be charged a no-show or late cancellation fee of $50.This fee is not covered by insurance.

Late Arrival Policy

We know that delays can happen when you are trying to get to your appointment. However, we must try to keep the other patients and doctors on time. If you arrive 15 minutes past your scheduled time, we may have to reschedule your appointment.

I, the undersigned, understand and agree to the policies stated. I certify that the information on this form is accurate, to the best of my knowledge.

_____ _____

Patient Name (Printed) Date

_____

Patient/Guardian Signature

MOMENT DENTAL
581 University Blvd., Ste 400
Round Rock, TX 78665
info@momentdental.com | (512) 244-3333

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (07/01/2006), and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x- rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible

victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. We will charge you a reasonable cost-based fee for expenses such as copies. If you request X-Rays, there will be a fee for any copies of films. You are not entitled to originals, only copies. Postage will be added if copies are to be mailed. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Details of all fees are available from the HIPAA Coordinator.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **(You must make your request in writing.)** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Signature: _____