RYAN DENTAL Group

PATIENT REGISTRATION

TODAY'S DATE:

Patient's Name Last First Middle Preferred	Date of Birth	Sex	Social Security Number

Patient's Address Street Apt City State Zip	E-Mail Address

Marital Status M S D W Under Age 18 - MINOR	Patient's/Guardian's Employer	Occupation

Cell Phone	Home Phone	Work Phone

Spouse's Name Last First Middle	Spouse's Employer	Spouse's Occupation

Cell Phone	Work Phone	Spouse Birthday

Person We Can Contact in Case of Emergency
Name Relationship Cell # Work # Home #

Emergency Contact Address

Other Family Members Who are Patients Here	Who Can We Thank for Referring You to Our Office

Closest Relative Not Living With You
Name Address Phone #

INSURANCE AND FINANCIAL INFORMATION

Insurance Coverage Yes No	Insurance Company Name Address	Phone #

Subscriber's Name	Patient's Relationship to Subscriber Self Spouse Dependent	Subscriber's Date of Birth	Subscriber's SSN

Group Number	ID Number	Employer Name

Secondary Coverage Yes No	Insurance Company Name Address	Phone #

Subscriber's Name	Patient's Relationship to Subscriber Self Spouse Dependent	Subscriber's Date of Birth	Subscriber's SSN

Group Number	ID Number	Employer Name

Assignment & Release

I hereby authorize my insurance benefits to be paid directly to the dentists. I am financially responsible for any balances due and authorize the dentists to release any information necessary for this claim. I consent to the making of photographs, x-rays, and videotapes before, during, and after treatment, and to their use by the doctor in scientific papers or demonstrations. I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of possible complications. I certify that I have read or had read to me the contents of this form and do realize the risks and limitations involved.

_____ _____ _____

Printed Name Patient / Guardian Signature Patient / Guardian Date

1650 E. Stacy Rd, Suite 100, Allen, TX 75002 Phone: 972-727-5001 Fax: 214-644-0077

Office@RDGAllen.com www.RDGAllen.com

Patient Name: _____ Date: _____

DENTAL HISTORY

What is the reason for your visit today? _____

_____

What is your previous dentist's name, address, and phone number?
Name: _____ Phone Number: _____
Address: _____State_____Zip_____

Date of your last dental visit: _____ Reason: _____
Date of most recent dental x-rays: _____

How often do you usually have dental cleanings? (circle one) **3**mos **4**mos **6**mos **12**mos **>12**mos

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

Please circle Yes or No to the following and briefly explain any yes responses:

		Dates/Explanations
Y N	unhappy with the appearance of your teeth	
Y N	nervous about having dental treatment	
Y N	unfavorable past dental experience	
Y N	problems with dental anesthetic	
Y N	history of orthodontic treatment (braces)	
Y N	history of oral surgery/extractions	
Y N	serious injury to the mouth or head	
Y N	history of periodontal treatment (surgeries, deep cleanings)	
Y N	bleeding gums	
Y N	loose teeth	
Y N	problems with food getting caught between teeth	
Y N	problems with dry mouth	
Y N	unpleasant odor or taste in your mouth	
Y N	areas of mouth sensitive (to hot, cold, sweets, biting, chewing)	
Y N	suffer from cold sores, fever blisters, or other oral lesions	
Y N	snore	
Y N	mouth guard (for athletics, snoring, grinding, TMJ pain, etc)	
Y N	jaw problems (clicking, popping, or pain in the joint)	
Y N	difficulty opening your mouth widely	
Y N	clench or grind your teeth	
Y N	tension headaches	
Y N	difficulty swallowing	

If you have a partial or complete denture, please complete the following:
Has your present denture been relined? Yes No If yes, when? _____
Is your present denture a problem now? Yes No If yes, describe: _____
When did you receive your first partial or complete denture? _____
How long have you been wearing your present denture? _____

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

Doctor's Signature_____**Date**_____

Patient Name: _____ Date: _____

RYAN DENTAL Group

MEDICAL HISTORY

What is your medical doctor's name, address, and phone number?
Name: _____ Phone Number: _____
Address: _____ State_____ Zip_____
Do you see any specialists? Yes No If yes, give name and specialty: _____
Date of your last physical examination: _____ Reason: _____

Circle Yes or No to the following and give dates and explanations as necessary

Y N	hospitalization for illness or injury	**Y N**	artificial joints (hip, knee, etc.)
Y N	chest pain	**Y N**	arthritis (osteo or rheumatoid)
Y N	heart surgery, disease, attack	**Y N**	glaucoma
Y N	heart murmur	**Y N**	contact lenses
Y N	artificial heart valves	**Y N**	epilepsy, convulsions, seizures
Y N	pacemaker	**Y N**	fainting/dizzy spells
Y N	atrial fibrillation	**Y N**	head injury
Y N	high blood pressure	**Y N**	venereal disease
Y N	low blood pressure	**Y N**	hepatitis (Type A, B, C)
Y N	high cholesterol	**Y N**	lumps/swelling in the mouth, neck, throat
Y N	stroke	**Y N**	cancer / non-cancerous tumors
Y N	anemia or other blood disorder	**Y N**	radiation therapy / chemotherapy
Y N	prolonged bleeding	**Y N**	immune problems/immunocompromised
Y N	COPD / emphysema	**Y N**	HIV/AIDS
Y N	tuberculosis	**Y N**	handicap (mental / physical)
Y N	asthma	**Y N**	psychiatric treatment
Y N	sleep apnea / snoring	**Y N**	antidepressant medication
Y N	kidney disease	**Y N**	anti-anxiety medication
Y N	liver disease/jaundice	**Y N**	prescription sleeping pills
Y N	thyroid or parathyroid disease	**Y N**	alcohol/drug dependency
Y N	hormone deficiency	**Y N**	cortisone medication
Y N	diabetes (Type I or II)	**Y N**	blood thinner medication
Y N	hypoglycemia	**Y N**	bone loss prevention meds(Actonel/Boniva/Fosamax/Etc.)
Y N	stomach or duodenal ulcer / reflux	**Y N**	history or current use of tobacco (smoke / smokeless)
Y N	digestive disorders	**Y N**	FEMALE taking birth control pills
Y N	hives, skin rashes	**Y N**	FEMALE pregnant or lactating

ALLERGIES Circle any of the following that you have had an allergic reaction to:

No Allergies Penicillin Erythromycin Aspirin Ibuprofen Acetaminophen

Codeine Latex Tetracycline Local Anesthetic Fluoride Metals

Other Allergies: _____

Have you ever been told by a doctor that you should take a pre-medication prior to dental treatment? Yes No
If yes, who advised pre-medication? (doctor's name) _____
What is the reason for the pre-medication? _____

Please describe any current medical treatment, impending surgery, or other treatment that you feel may possibly effect your dental treatment: _____

_____

List all medications you are currently taking, including drug <u>name</u>, <u>dose</u>, and <u>reason</u> you take the medication:

_____

_____

If you have extensive medical conditions, medications, allergies, or anything else you feel we need to know and don't have room in the blanks above, please provide a separate list with a date on it that we can attach to this form .
AT EACH APPOINTMENT, BE PREPARED TO PROVIDE AN UPDATED LIST OF ALL OF YOUR MEDICATIONS. ALSO, PLEASE ADVISE US OF ANY CHANGES TO YOUR MEDICAL HISTORY.

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

Doctor's Signature_____**Date**_____

Financial, Contact, and Appointment Information for Ryan Dental Group

Financial Info

At Ryan Dental Group, our primary goal is to provide you with the best and most comprehensive dental care available. To make the cost of your care as easy and manageable as possible, we offer several payment options. You can choose to pay by cash, check, or major credit card. We can also help get you started with a credit card for medical expenses only called Care Credit. The ability for you to use Care Credit as an option is subject to credit approval. If approved, there is no interest when the balance is paid within the specified time period set forth by the credit card agency. Minimum monthly payments are required. If you are interested in this option, we have informational brochures available to give you.

A Note About Estimates and Insurance

Many of your out-of-pocket costs on the day of treatment, or the expected out-of-pocket costs explained to you when the treatment is first proposed, are based on ***estimates*** we receive from your insurance company. Although we do our best to verify benefits and check on the status of deductibles if applicable, it is inevitable that some insurance claims for treatment will not get covered by the insurance companies as was expected. In the event that this happens, the staff of Ryan Dental Group can appeal to your insurance company, but if some fees still end up not being covered as had originally been estimated, you will be responsible for the remaining balance. Likewise, if insurance pays more than we expected, a credit will be applied to your account. If problems arise with your dental insurance, it is often helpful for you to contact your human resource manager or the insurance company directly to help resolve the issues. Balances still pending with insurance after 60 days become the patient's responsibility.
As always, we are happy to answer any questions you may have about your dental insurance. We appreciate the opportunity to provide your dental care.

Contact Info

List any individuals below who you consent for us to share your protected health information with, including but not limited to appointment times, treatment needs, and insurance/account information.

____

Name of individual we may share information with | Relationship to Patient

____

Name of individual we may share information with | Relationship to Patient

List below anyone who you specifically request we do NOT share information with.

____

Name of individual you do **NOT** want information shared with | Relationship to Patient

Appointment Info

Last minute cancellations of appointments and failure to show up for scheduled appointments are very hard on a dental office. These hurt you, the dentist, and other patients who may be in need of care and waiting for an available appointment. We require a minimum of 24-hours advance notice from your scheduled appointment time if you need to cancel or reschedule your appointment. Habitual failure to give us the courtesy of 24-hours advance notice for needed schedule changes may result in fees being charged to you.

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Please sign below to verify that you have read, understand, and agree to all of the above.

____

Printed Name of Patient Signature of Patient/Guardian/Responsible Party Date
~~~~~~

RYAN DENTAL Group

Appointment Policy

Cancellations
If the need arises to cancel a scheduled appointment, we request a cancellation notice of **at least** 24 hours *from you scheduled appointment time*. This allows us time to contact and schedule a patient from the waiting list in the time slot that was previously reserved for you.

No-Shows
When you no-show an appointment, you hurt 3 people: yourself, the dentist, and other patients who may be in need of care and waiting for an open appointment. Additionally, each operatory receives a custom set-up depending on the treatment needs of the individual patient. There are costs and unnecessary wastes incurred by the office associated with the set-up and tear-down/sterilization of an operatory.

Late Policy
If you are going to be more than 15 minutes late, please call our office. In the event that your tardiness will cause other patients to not be seen on time, or will not allow the doctor/hygienist sufficient time to complete your treatment, the appointment may be canceled. Cancellations resulting from your tardiness will be considered as a no-show appointment.

Appointment Cancelled Without 24-Hour Notice	**Fee $25.00**
No-Show for Appointment	**Fee $50.00**
Late Arrivals Resulting in Cancellation	**Fee $50.00**

These charges will not be billed to insurance; you will be responsible for payment. By signing below, you acknowledge your understanding of the policy and you agree to pay.

Habitual (3 or more) cancellations without sufficient notice, no-shows, or tardiness may result in dismissal from the practice.

Please sign below to indicate you have read and understand our appointment policy. You may request a copy to keep for yourself.

_____ _____ _____

Printed Name Patient / Guardian Signature Patient / Guardian Date

1650 E. Stacy Rd, Suite 100, Allen, TX 75002 Phone: 972-727-5001 Fax: 214-644-0077
Office@RDGAllen.com www.RDGAllen.com

RYAN DENTAL Group

HIPAA
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 the Notice while it is in effect. This Notice 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 opportunities, 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 judgement 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, letters, email, or text).

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. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.20 for each page, $10 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have a 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, but not before April 14, 2003. 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.) You request must specify the alternative means or location, and provide satisfactory explanation of 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 upon request.

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.

Contact Officer: Laura Ryan, D.D.S
Telephone: (972)-727-5001
Fax: (214)-644-0077
E-mail: Office@RDGAllen.com
Address: 1650 E. Stacy Rd, Suite 100, Allen, TX 75002

RYAN DENTAL Group

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES
&
CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice has been provided for you to review. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, by contacting:

Contact Officer: Laura Ryan, D.D.S
Telephone: (972)-727-5001 Fax: (214)-644-0077 E-mail: Office@RDGAllen.com
Address: 1650 E. Stacy Rd, Suite 100, Allen, TX 75002

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. 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 or to continue treating you if you revoke this Consent.

SIGNATURE
I have had full opportunity to read and consider the contents of this Consent form and the Notice of Privacy Practices. I understand that, by signing this form, I am acknowledging my receipt and understanding of the Notice and I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Print Patient Name _____

Your Signature _____ Date _____

If signed by someone other than the patient, please continue below:

Your Printed Name: _____ Relationship to Patient: _____

Copies of this form are available upon request

For Office Use Only

Acknowledgement and consent could not be obtained because:

____ Individual refused to sign

____ Communication barriers prohibited obtaining the acknowledgement

____ An emergency situation prevented us from obtaining acknowledgement

____ Other (please specify) _____

REVOCATION OF CONSENT

____ Patient revoked consent on this date: _____. Written notice of the patient's revocation was received.

Staff Signature _____ Doctor Signature _____