M&G Family Dentistry
New Patient Registration Form

Patient Information:

Patient Name: _____

Birth Date: _____ Age: _____ Male____ Female ____ Other_____

State ID or Driver License_____ State:_____ SS#_____

Home Address: _____City/State/Zip: _____

Home Phone #:_____ Work Phone: _____

Cell Phone #:_____ Employer: _____

Email address:_____@_____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
How did you hear about our office? _____
Emergency Contact Person: _____ Phone :_____

**Please provide our receptionist with a Valid Phot ID (State ID or Diver License or Passport) and your current Insurance Card.

Responsible Party Information: (If *not* the patient, please complete)

Parent or Spouse Name: (circle one) _____
Address: (if different from above) _____
Phone #:_____ Cell Phone #:_____ Is this person currently a patient? Y or N
Birth Date: _____SS#_____
Employer: _____ Work Phone: _____

Insurance Information: (If *other than* patient or responsible party please complete below)

Please Present office with your insurance Card and Driver License.

Primary Subscriber Policy Holder Name: _____SS#:_____
Patient Relation to Primary Subscriber _____Self _____Spouse_____Child_____Other:_____
Primary Policy Holder Birth Date: _____Phone: _____
Insurance Company Name :_____ Insurance Type : ____PPO_____DHMO
Primary Policy Holder Insurance #_____ Group Name or Number_____
Insurance Company Provider Phone #_____(on the back of your ins card)
Employer: _____ Work Phone #:_____

Dental Insurance Assignment of Benefits Authorization and Release

As a courtesy of our dental office, we will gladly assist you in verifying, filing, billing and collecting your insurance claim, but we are unable to accept responsibility for denied claim after appeals . It is your responsibility to pay for the entire amount not covered by your dental benefit plan. You also assign that any insurance checks or payment sent to you in regards of your dental treatment performed at M&G Family Dentistry, shall be forwarded or sent or delivered to M&G Family Dentistry in person or via certified mail.
All accounts 30 days and over are past due and subject to interest.

By signing below, I certify that I have completed the above information to the best of my knowledge.
Responsible Party's Name :_____
Responsible Party's Signature_____ Date_____
Name of Patient or Parent _____
Signature of Patient or Parent_____ **Date_____**

Patient Medical History: (Please, Place a Circle)

Physician's Name: _____ Phone #:_____ Date of last visit:_____

1. Are you under medical treatment now? Yes No
2. Have you ever been hospitalized for any surgical operation or serious illness? Yes No
3. Are you taking any medication(s), including non-prescription medications or diet pills? Yes No
   Please List:_____
   _____
   _____(use separate sheet if needed)
4. Do you use alcohol? Yes No
5. Do you use Tobacco? Yes No
6. Are you taking any type of Blood thinners or Blood altering Medications: anti-platelets or anti-coagulants? Yes No
   List:_____

7. Are you allergic to or have any reactions to the following?

Local Anesthetics (e.g. Lidocaine)	Yes	No
Penicillin or other Antibiotics	Yes	No
Latex	Yes	No
Narcotic Drugs (e.g. Percodan)	Yes	No
Barbiturates	Yes	No
Sedatives	Yes	No
Aspirin	Yes	No
Metal _____	Yes	No

Other Allergen not listed above_____

8. Women Only:

Are you pregnant or think you may be pregnant	Yes	No
Are you nursing?	Yes	No
Are you taking birth control	Yes	No

List:_____

9. Are you taking any type of bisphosphonates or any other Bone Density Altering medication? Yes No
   If Yes, List Name :_____Frequency _____Since _____
10. Are you taking any Immunosuppressive Medication? Yes No
    If Yes, List Name :_____Frequency _____Since _____
11. Are you taking any type of Hormone Replacement medications? Yes No
    If Yes, List Name :_____Frequency _____Since _____
12. Do you have or have you had any of the following? (Please, Check and Explain below)

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack or Surgery	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Hay Fever/Allergies	☐	☐	Angina	☐	☐
Fainting/Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Respiratory Problems	☐	☐	Radiation Therapy	☐	☐	Anemia	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy/Convulsions	☐	☐	Recent Weight Loss/Gain	☐	☐	Cancer	☐	☐
Artificial Heart Valve	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Mitral valve Prolapse	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Disease	☐	☐	Hepatitis/Jaundice	☐	☐	Asthma	☐	☐
AIDS/HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Diabetes	☐	☐
Thyroid Problems	☐	☐	Stomach Problems/Ulcers	☐	☐	Leukemia	☐	☐
Artificial Joints	☐	☐	Osteoporosis (Bone weakness)	☐	☐	Bone Problems	☐	☐

Other Problems: _____

Explanation: _____

Patient Dental History: (Please, Place a Circle)

How long since your last: Dental Visit: _____ Cleaning: _____ X-rays:_____

1. Do your gums bleed while brushing or flossing ? Yes No
2. Are your teeth sensitive to hot or cold foods/liquids? Yes No
3. Are your teeth sensitive to sweet or sour foods/liquids? Yes No
4. Do you have any sores or lumps in or near your mouth? Yes No
5. Have you had any head or neck injuries? Yes No
6. Have you ever experienced any of the following problems in your jaw? Pain (joint, ear, side of face) Difficulty in opening or closing Difficulty in chewing
7. Do you have frequent headaches? Yes No
8. Do you clench or grind your teeth? Yes No
9. Have you ever had any difficult extractions? Yes No
10. Did you wear braces? Yes No
11. Have you had prolonged bleeding following dental extraction? Yes No
12. Have you ever had instruction on brushing or flossing? Yes No

By signing below, I certify that I have completed the above information to the best of my knowledge.

Name Signature Date

Doctor Signature _____Date _____

M&G Family Dentistry
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly, Obtain payment from designated third-party payers, Conduct normal health care operations such as quality assessments or evaluations, and physician certifications.

I have been informed by M&G Family Dentistry- Notice of Privacy Practices that contains a more complete description of the uses and disclosures of my health information (available at M&G Website or in office in print form).

I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that M&G Family Dentistry has the right to change its Notice of Privacy Practices from time to time and that I may contact M&G Family Dentistry at any time to obtain a current copy of the Notices of Privacy Practices. I understand that I may request in writing that M and G Family Dentistry restricts how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand M&G Family Dentistry is not required to agree to my requested restrictions, but if M&G Family Dentistry does agree, then it is bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that M&G Family Dentistry has taken action relying on this consent.

By Signing Below, I acknowledge that I received, read, understood and agreed with M&G family Dentistry Notice of Privacy Practices.

Patient name or legal Guardian:_____
Signature: _____
Date:_____

Authorization To Release Private Health Information

Please, fill this section ONLY : **If you would like us to discuss or release your information with any other party other than yourself (patient).**

I_____ hereby authorize M&G Family Dentistry (Doctors, Staff & representative) to release my private health information limited to:
_____ Treatment Only _____ Billing _____Both Treatment & Billing
To the following parties: (If Any)
Name :_____ Phone:_____Relation to patient:_____
Name :_____ Phone:_____ Relation to patient:_____
Name :_____ Phone:_____ Relation to patient:_____
For lifetime _____ For Only a Period of :_____starting From:_____/_____/_____

Patient name or legal Guardian:_____
Signature: _____
Date:_____

M&G Family Dentistry
Communication & Contact - Consent Form

M&G Family Dentistry may wish to contact you for several reasons including but not limited to: setting up appointment, confirming appointment, following up after procedures, discussing financial matters, discussing insurance matters, referrals, current or future promotions.

M&G Family Dentistry uses several methods of communications including but not limited: In person, Phone calls, Text Messages, Emails, Mail, other types of social media……etc

Please initial your preferred method of contact:

- **I consent to receive electronic communication via emails and/or text message. [_____] Initial.**
- **I wish to be contacted by phone only. [_____] Initial**.

You can always change or withdraw your consent at any time by phone or in writing.

M&G Family Dentistry will not disclose or share any of your information to anyone or 3rd party without your written signed release. As with Any form of communication, there are some risks that any Personal health information [PHI] and other sensitive or confidential information that may be leaked, misdirected, disclosed to or intercepted by unauthorized third parties.

Patient name or legal Guardian:_____
Signature: _____
Date:_____

M&G Family Dentistry
Financial Policy and Agreement

The following statement is our financial policy which we require that you read, discuss any concern and sign prior to any treatment.

General:
Payment of your bill is considered part of your treatment. Regardless of any insurance status, you are responsible for the balance due on your account. You are responsible for any and all professional services rendered unless it is covered by your insurance : dental, surgical , office visit fees , procedures, tests, office procedures, medications, infection control fees, lab upgrade fees when required and also any other services not directly provided by the dentist.

APPOINTMENTS:
Any Missed, cancelled or rescheduled in less than 48 hours' notice, your account will be charged $25.00. [_____] Initial.

INSURANCE:
Please remember your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy to you, our office provides certain services, including insurance verifications, billing, pre-treatment estimates which requires tremendous efforts and cost. It is physically impossible for us to have knowledge and keep track of every aspect of your insurance.
It is up to you to contact your insurance company and inquire as to what benefits you or your employer has purchased for you. If you have any questions concerning your Pretreatment estimates and/or fees for service, it is your responsibility to have these answered prior to treatment to minimize any confusion on your behalf.
Pretreatment estimates are just estimates; and are not a guarantee of any payment , final adjustments occur after insurance pays or denies payments; we will appeal any denial for 1 or 2 times then you are responsible for the amount due**.** Regardless of any insurance status, you are responsible for the balance due on your account. [_____] Initial.

PAYMENT:
FULL PAYMENT is due before or at the time of service. If insurance benefits apply, Pretreatment Estimate, CO-PAYMENTS and DEDUCTIBLES are due before or at the time of service, unless other financial arrangements are made.
[_____] Initial.

ACCOUNT BALANCE:
Unpaid balance over 30 days will be subject to monthly interest. All balances 90 days past due may be turned over for collection. In the event, you or your insurance company fail to pay and it is necessary to employ outside collections efforts, you are responsible for reasonable costs for collection, including but not limited to court costs, attorney fees and collection agency fees ,in addition to the balance due on the account. [_____] Initial.

All parties agree that in event of a dispute over any balance due to M&G Family Dentistry by the undersigned, Harris County courts shall have exclusive jurisdiction and venue for any litigation filed by either party. [_____] Initial.

*By signing, I understand and agree to the terms, clauses and conditions of this Financial Agreement.
Patient name or legal Guardian: _____
Signature: _____
Date: _____

M&G Family Dentistry

NEW PATIENT EXAM AND X-RAY CONSENT FORM

Consent for Comprehensive Dental Exam and X-rays:

I give my permission to take the necessary radiographs (x-rays), photographs, periodontal (gum) measurements and plaque specimen, charting of existing restorations, diagnostic casts (models of teeth), and bite records to provide data for the assessment of my dental health.

Furthermore, I authorize Comprehensive Dental Exam and X-rays of my dental condition including, but not limited to:
*American Cancer Society Head/Neck, (intra/extra oral) cancer screening
*TMJ evaluation
*Periodontal evaluation
*Complete inventory of existing restorations
*Radiographic evaluation of oral/head/neck structures as needed
*Evaluation of occlusion of teeth (how they come together)
*Evaluation of dental/facial esthetics using photographs as needed
*The development of a personalized life-long plan for dental health

Name: _____
Signed: _____ Date: _____

Consent for Limited Exam& X rays and Informed Refusal Comprehensive Exam:

I have been informed of the need for a complete dental examination to fully assess my dental needs. I choose to forego this examination at this time and will be responsible for any ramifications due to my refusal of this service.

I do give permission to perform a problem focused exam and x-ray limited to the evaluation of a specific Area or tooth. Due to the limited nature of this exam, I understand that M&G Doctors & staff are unable to diagnose or advise and are not responsible (to address or diagnose or treat or prescribe medication to or for) or any other conditions or problems related to my dental health.

Name: _____
Signed: _____ Date:_____