ADVANCED DENTAL CARE of HUTTO

Advanced Dental Care of Hutto
401 Ed Schmidt Blvd., Suite 100
Hutto, TX 78634
(512) 846-2011

REGISTRATION FORM (PLEASE PRINT)

Reason for your visit:	Date of last dental visit:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	Preferred name:
Preferred contact method: ❑ Phone ❑ Email	Email address:	Birth date:	Age:	Gender: ❑ M ❑ F
Home phone:	Work phone:	Other phone:	
Street address:	City:	State:	ZIP code:
Patient social security number:	Marital status (check one) ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widow	Other family members seen here:	

RESPONSIBLE PARTY/INSURANCE INFORMATION

Name of Parent/Subscriber:		Employer:	
Home phone:	Work phone:	Employer phone:	
Date of birth:		Social security number:	
Insurance name:	Other insurance: ❑ Yes ❑ No	Group number:	Insurance phone:

CONSENT FOR SERVICES

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the doctor, I agree to pay therefore the reasonable value of said services to said doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to your assignee to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or guardian:	Relationship to patient:	Date:
Signature of guarantor of payment/responsible party	Relationship to patient:	Date:

HAVE YOU EVER HAD ANY OF THE FOLLOWING? PLEASE CHECK ALL THAT APPLY			
❑ AIDS / HIV	❑ Epilepsy	❑ Jaundice	❑ Sinus Problems
❑ Allergies (list below):	❑ Excessive Bleeding	❑ Kidney Disease	❑ Stomach Problems
	❑ Fainting	❑ Liver Disease	❑ Stroke
❑ Anemia	❑ Glaucoma	❑ Mental Disorders	❑ Tuberculosis
❑ Arthritis	❑ Growths	❑ Nervous Disorders	❑ Tumors
❑ Artificial Joint	❑ Hay Fever	❑ Pacemaker	❑ Ulcers
❑ Asthma	❑ Head Injuries	❑ Pregnancy Due Date:	❑ Venereal Disease
❑ Blood Disease	❑ Heart Disease	❑ Radiation Treatment	❑ Codeine Allergy
❑ Cancer	❑ Heart Murmur	❑ Respiratory Problems	❑ Penicillin Allergy
❑ Diabetes	❑ Hepatitis	❑ Rheumatic Fever	❑ Other (list in box below):
❑ Dizziness	❑ High Blood Pressure	❑ Rheumatism	

Have you ever had any complications following dental treatment?	❑ Yes	❑ No
If yes, please explain:		

Have you ever been admitted to a hospital or needed emergency care during the past two years?	❑ Yes	❑ No
If yes, please explain:		

Are you now under the care of a physician?	❑ Yes	❑ No
If yes, please explain:		
Name of Physician:		

Do you have any health problems that need further clarifications?	❑ Yes	❑ No
If yes, please explain:		

ACKNOWLEDGEMENT

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian:	Relationship to patient:	Date:

ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have been offered a copy of this office's Notice of Privacy Practices.
(Please print name)

Signature of patient, parent or guardian:	Relationship to patient:	Date:
Signature of Doctor:		Date:

HOW DID YOU HEAR ABOUT US?					
❑ Family	❑ Friend	❑ Internet	❑ Facebook	❑ Yellow Pages	❑ Dr._____
❑ Patient	❑ Brochure	❑ Hospital	❑ Yelp	❑ Insurance Plan	❑ Other_____
Like us on Facebook and stay tuned for prizes, specials and reminders.					facebook.com/adchutto