Patient Registration Information **CONFIDENTIAL**

Welcome to our practice! Thank you for selecting our dental healthcare team. Please fill out this form completely in ink. If you have any questions or concerns, please do not hesitate to ask for assistance-we will be happy to help.

Date ______________________

Patient Name____
First MI Last

Is a family member of this person currently a patient in our office? yes ___no__ If yes who? ___________________________

Home address ____City ________ State __ Zip_______

SS# ________________________ Birth date ___________________________

Phone: Home________________ Cell_________________ Email _____________________________

Preferred communication method(s): Home ____ Cell ___ Email____

May we send a text message to remind you of your upcoming appointment? Yes ___ No__

Are you: _____Minor _____Single _____Married _____Divorced _____Separated _____Widowed

You or your parents' employer: ______________________________ Occupation:__________________

Spouse or parents' name: ____
Person to contact in case of an emergency: _________________________ Phone ___________________

RSPONSIBLE PARTY
Person responsible for this account _____________________________ Relationship _______________
Address ____Phone ____________________

Family Dentist Name ___________________________ Phone ___________________________

INSURANCE INFORMATION
Name of Insured _________________________Relationship to Patient __________________________

Birth date______________________________SS # ____

Employer Address ______________________________City________________State___Zip _______

Insurance Company_____________________________________Phone _________________________

Release I understand that accurate and complete diagnosis is an essential first step in my dental care and authorize Dr. Paul Chang to perform diagnostic procedures as may be necessary to achieve an accurate and complete diagnosis. I also understand that effective diagnosis and treatment may necessitate the involvement of other health professionals in my care and therefore authorize release of any information concerning my (or my child's) health care, advise, and treatment to another dentist or physician.
While I understand that I am ultimately responsible for all dental treatment fees, I would appreciate the offices assistance in submitting to my insurance company for reimbursement. I authorized release of any information concerning my (or my child's) health care, advise or treatment provided for the purpose of evaluating and administering claims for insurance benefits and securing payment for treatment. I authorize payment of insurance benefits be made directly to Dr. Paul Chang's office.

X____

Signature of patient or parent if minor Date

Thank you for filling out this form completely. The information you have provided will help us serve your dental healthcare more effectively and efficiently. If you have any questions at any time, please ask us. We are always happy to help.

MEDICAL HISTORY

PATIENT ___________________________________ DATE ________________
NAME OF PHYSICIAN________________________ PHONE_______________
CLINIC OR FACILITY NAME____
WHOM MAY WE NOTIFY IN CASE OFAN EMERGENCY? NAME_____________
Relationship to you_________________________ PHONE_________________

Circle a definite answer for each question:

Yes No ANY CHANGE IN YOUR HEALTH IN THE LAST TWO YEARS?
Yes No ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN?
IF YES, DESCRIBE YOUR TREATMENT____
____

Yes No HAVE YOU HAD ANY MEDICAL TREATMENT OR PHYSICIAN VISIT OF ANY KIND IN THE LAST TWO YEARS? IF YES, DESCRIBE____
Yes No HAVE YOU EVER HAD ANY SURGICAL OPERATION OF ANY KIND? IF YES, DESCRIBE ____
Yes No WERE YOU TRANSFUSED AT THAT TIME?
Yes No HAVE YOU BEEN ADVISED BY A PHYSICIAN OF THE NEED FOR ANY TYPE OF SURGERY OR TREATMENT? FOR WHAT? ____

DO YOU HAVE, HAVE YOU HAD, OR BEEN TREATED FOR, ANY OF THE FOLLOWING:

Yes	No	ARTHRITIS	Yes	No	THYROID CONDITION
Yes	No	RHEUMATIC FEVER	Yes	No	VENEREAL DISEASE, HERPES Type II
Yes	No	HEART PROBLEMS	Yes	No	ACQUIRED IMMUNE DEFICIENCY SYNDROME
Yes	No	HIGH BLOOD PRESSURE	Yes	No	PACEMAKER TYPE
Yes	No	LOW BLOOD PRESSURE	Yes	No	HIP OR JOINT REPLACEMENT
Yes	No	ANEMIA, SICKLE CELL DISEASE	Yes	No	RADIATION OR CHEMICAL THERAPY
Yes	No	EPILEPSY, SEIZURES	Yes	No	FAINTING SPELLS
Yes	Nka	ALLERGY	Yes	No	CHEMICAL DEPENDENCY
Yes	No	DIABETES	Yes	No	CHRONIC DIARRHEA
Yes	No	HEPATITIS	Yes	No	HYPOTHERMIA
Yes	No	ULCERS	Yes	No	EAR INFECTIONS
Yes	No	KIDNEY DISORDER	Yes	No	CHRONIC SINUS
Yes	No	TUBERCULOSIS	Yes	No	ASTHMA
Yes	No	ENZYME DEFICIENCY	Yes	No	HEMOPHILIA. BLEEDING OR BLOOD DISORDER
Yes	No	HIV	Yes	No	MITRAL VALVE PROLAPSE
Yes	No	HYDROCEPHALUS	Yes	No	AIDS RELATED COMPLEX
Yes	No	ANOREXIA, BULIM1A	Yes	No	HEART MURMUR

Yes Nka HAVE YOU EVER HAD AN ALLERGIC REACTION OR BEEN TOLD NOT TO TAKE ANY MEDICATION? IF YES, DESCRIBE____
Yes No ARE YOU CURRENTLY TAKING ANY PRESCRIPTION DRUGS OF ANY KIND (Example: Birth Control, Hormone, Diet)? IF YES, WHAT ____
Yes No ARE YOU CURRENTLY TAKING ANY NONPRESCRIPTION DRUGS OF ANY KIND (Example: Aspirin, Cough Syrup, Nasal Spray. Recreational Drug Use, Sugar, Caffeine)?
IF YES, WHAT? ____
Yes No ARE YOU PREGNANT? ANTICIPATED DELIVERY DATE ______________________________
Yes No DO YOU USE ANY TOBACCO PRODUCT? DAILY INTAKE______________________________
Yes No DO YOU WEAR CONTACT LENSES?
BLOOD PRESSURE:_________/___________ Pulse ________

I CERTIFY THE ABOVE TO BE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

SIGNATURE ____________________________________ DATE ____
Patient or Guardian of Minor

PERIODONTICS & IMPLANT CENTER OF MCKINNEY
321 N. Central Expwy., Suite *102*
McKinney, Texas 75070
972-540-5700

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 *4Li4LZ.OO~,* 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 receive 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 or 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 for 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 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 healthcare 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, or 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.

PERIODONTICS & IMPLANT CENTER OF MCKINNEY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I have received a copy of this office's Notice of Privacy Practice.

____
(Please print name)

____
(Signature)

____
(Date)

For office use only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, however acknowledgement could not be obtained because:

Individual refused to sign

____ Communications barriers prohibited obtaining the acknowledgement

____ An emergency situation prevented us from obtaining acknowledgement

____ Other (Please Specify)

____
____
____

PERIODONTICS & IMPLANT CENTER OF MCKINNEY
321 N. Central Expwy., Suite 102
McKinney TX 75070

Consent for Photography

Patient Name: ____________________ DOB: _______________ Account#:___________

Parent or Legal Guardian: ____

I consent to have my (or child or an individual to whom I provide guardianship) image to be taken by the staff at Periodontics & Implant Center of McKinney as described below.

I understand that my (or child or an individual to whom I provide guardianship) photographs, videotapes, digital, and other images may be recorded to document and assist with my care and the payment of my bill (or child or an individual to whom I provide guardianship). These images may be used to assist in the education of fellow dentists. I understand that the Periodontics & Implant Center of McKinney will own these images, but that I will be allowed access to view them or to obtain copies of them at a reasonable cost. Other than for treatment, education, and payment purposes, images that identify me (or child or an individual to whom I provide guardianship) will be released and/or used outside the organization only upon written authorization from me or the patient representative.

If the images are to be taken for any purpose other than for treatment, education, or payment purposes, the purpose(s) must be stated:____
____

I may revoke or withdraw this consent at any time. Such withdrawal of consent must be made in writing. Withdrawal of consent does not affect any information disclosed prior to the written notice of withdrawal.

I release and hold harmless Periodontics & Implant Center of McKinney, its staff and employees from any and all claims or causes of action that I may have of any nature whatsoever, which may in any manner result from the use of the photograph or other image.

By signing below, I am indicating that I have read and understand the "Consent for Photography" form. I am either the patient or have the authority to give consent for the patient. My questions regarding this consent have been answered.

____ _________________________________
Patient or Patient Representative Signature **Date**

____ _________________________________
If Patient Representative, Relationship to Patient **Printed Name**