TIME 1:36 PM DATE 7/30/2012

PATIENT REGISTRATION

ID: _____ Chart ID: _____

First Name: _____ Last Name: _____ Middle Initial: _____

Patient Is: ☐ Policy Holder Preferred Name: _____

☐ Responsible Party

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

◯ Responsible Party is also a Policy Holder for Patient ◯ Primary Insurance Policy Holder ◯ Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ State / Zip: _____ _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ◯ Male ◯ Female Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic: _____

E-mail: _____ ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ◯ Full Time ◯ Part Time ◯ Retired

Student Status: ◯ Full Time ◯ Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

Section 3

Referred By: _____

Previous Dentist: _____

Emergency Contact: _____

Emergency Contact #: _____

Relation to patient: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No _____
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pace Maker ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No	Yellow Jaundice ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No	

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Central Family Dental
Joseph Kim Drinkwater, D.D.S.
3106 South W.S. Young
Suite 202
(254) 519-2875
FAX (254) 519-2877
Office Contact: Laurie Bonfiglio

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient name_____

I authorize **Central Family Dental** to use and disclose my health information for the the purpose of treatment, payment and health care operations.

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. If you want to revoke your authorization, send us a written note telling us that you wish to have your authorization revoked. Send this note to the office contact person listed at the top of this form.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM AND STATED IN OUR NOTICE OF PRIVACY PRACTICES .

Dated_____ Patient signature_____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Print Name_____

Relationship _____

Signature_____

Central Family Dental

Joseph Kim Drinkwater, D.D.S.

Office Guidelines

Please initial each paragraph and sign below.

_____1. **PARENTS OR GUARDIANS OF MINOR CHILDREN MUST REMAIN ON THE PREMISES WHILE THE DENTIST IS SEEING THEIR CHILD.**

_____2. **PATIENT OR GUARDIAN AFTER RECEIVING A CONFIRMATION CALL. MUST CALL BACK TO CONFIRM THAT APPOINTMENT(S)**

_____3. LATE OR MISSED APPOINTMENTS: Missed appointments are one of the most serious problems facing the health care system today. An appointment on our schedule is a bond of trust that we will be here to serve you and you will be present for treatment. Our office policy is firm in this regard, and we cannot accommodate frequent cancellations or short notice changes. Therefore, if you are more than 15 minutes late, we may ask you to reschedule your appointment, or if you are unable to come to your appointment, we ask that you give us 24-hour notice. **Failure to keep your scheduled appointment without 24-hour notice will either result in a $100.00 fee being charged to your account or termination of the family's doctor/patient relationship.**

_____4. PAYMENT AND INSURANCE: As a convenience to you, our staff will submit charges for services to your insurance carrier. We are familiar with most insurance companies and will help you to receive the maximum allowance benefits, but patients should be aware of their policy's limitations, and we consider the patient *primarily* responsible for the account. When assignment is involved, the only portion which is not covered by insurance is due at the time of service. The patient co-payment may be paid in several ways: cash, Master Card, Visa, Discover, or an ATM Debit Card. **If, after filing the insurance, there is a balance, the patient is responsible for that portion of the bill. If balance is not paid in a timely manner we will add a 25.00 late fee for every billing cycle until balance is paid. If your account becomes past due, a collection fee may be added to the amount owed.**

_____5. TREATMENT ROOMS: Due to limited space, only the patient is allowed into the treatment rooms. After the initial exam and/or treatment is completed, the parent will be asked back to the treatment area to discuss the patient's dental needs. If you feel your child would be better served with you present for treatment, please bring this to the doctor's attention at the time of the initial exam.

_____6. CHANGE OF ADDRESS: In order that we may keep our records current, please inform us of any change of address or telephone numbers.

_____ _____

Responsible Party Date

3106 South W. S. Young Killeen, Texas Telephone: (254) 519-2875 Fax (254) 519-2877

NOTICE OF PRIVACY PRACTICES

Central Family Dental
Joseph Kim Drinkwater, D.D.S.
3106 South W.S. Young Suite 202 (254) 519-2875 FAX (254) 519-2877
Office contact: Laurie Bonfiglio

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for the following reasons:

- Your dental treatment
- Payment or health care operations
- In order to refer you to another health care professional
- Prescribing medication
- Getting your dental records and x-rays from another office
- Sending bills and claims
- Seeking information from your dental insurance company
- Collecting unpaid amounts (either ourselves or through a collection agency or attorney)
- We may use or disclose your health information when we are required to do so by law

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we usually will not ask you for special written permission.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law.
If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- Ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations.
- Ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E-Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost.
- Ask to see or to get photocopies of your health information. A fee of 25.00 may be charged.
- Ask us to amend your health information if you think that it is incorrect or incomplete.
- Get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want).
- Get additional paper copies of this Notice of Privacy Practices upon request.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more detailed information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

ACKNOWLEDGEMENT

I acknowledge that I have read a copy of Joseph Kim Drinkwater's Notice of Privacy Practices.

Patient name _____

Signature _____ Date _____

Central Family Dental
Joseph Kim Drinkwater, D.D.S
3106 South W.S Young
Suite 202
Killeen, TX 76542
Telephone 254-519-2875

Payment Options

To help keep cost of dentistry down and to continue to provide quality care to our valued patients, we now only accept payment in full the day of treatment.

Please check the option(s) most convenient for you to settle your account in full today.

( ) Cash/Debit

( ) Visa Account #_____ Exp Date: _____

( ) MC Account # _____ Exp Date: _____

( ) AMX Account # _____ Exp Date: _____

( ) Disc Account # _____ Exp Date: _____

( ) In House Credit Plan (Please See Office Manager For Application Form)

I _____ hereby authorize the Central Family Dental to process payments, from time to time with patient prior consent to settle my account in full.

Signature: _____ Date: _____