AEGIS DENTAL

NEW PATIENT REGISTRATION FORM.

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

Patient Information:

Address: _____ Address 2: _____
City: _____ State: _____ Zip code: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Sex: ○ Female ○ Male Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed
Birth date: _____ Social Security #: _____ Driver's License #: _____
E-mail: _____ □ I would like to receive email correspondences

Patient is: □ Responsible Party □ Policy Holder

Responsible Party: (If someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____
Address: _____ Address 2: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Birth date: _____ Social Security #: _____ Driver's License #: _____

○ Responsible Party is Policy Holder for Patient ○ Primary Policy Holder ○ Secondary Policy Holder

Patient Information (section 2):

Employment Status: ○ Full Time ○ Part Time ○ Self Employed ○ Retired ○ Unemployed
Student Status: ○Full Time ○ Part Time
Emergency Contact Person: _____ **Phone #:** _____

Primary Insurance Information:

Name of Insured: _____ Relationship to Insured: ○Self ○Spouse ○Child ○ other
Insured Social Security #: _____ Insured Birth date: _____
Employer: _____ Address: _____
City: _____ State: _____ Zip: _____
Insurance Company: _____ Address: _____
City: _____ State: _____ Zip: _____
Employer ID: _____ Carrier ID: _____ Member ID: _____
Group Name; _____ Group #: _____ Payor ID: _____

Medicaid ID: _____ Medicaid Insurance Company: _____
Medicare ID: _____ Medicare Insurance Company: _____

Secondary Insurance Information:

Name of Insured: _____ Relationship to Insured: ○Self ○Spouse ○Child ○ other
Insured Social Security #: _____ Insured Birth date: _____
Employer: _____ Address: _____
City: _____ State: _____ Zip: _____
Insurance Company: _____ Address: _____
City: _____ State: _____ Zip: _____
Employer ID: _____ Carrier ID: _____ Member ID: _____

Group Name; _____ Group #: _____ Payor ID: _____

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MEDICAL HISTORY FORM

PATIENT NAME _____ BIRTHDATE _____

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
Do you need to pre-medicate? [ ] Yes [ ] No If yes, please explain: _____

Women: *Are you Pregnant/Trying to get pregnant*? [ ] Yes [ ] No *If yes, # of weeks* _____ *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/Fever Blisters	Yes	No	Scarlet Fever	Yes	No
Angina Pectoris	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/Bone	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			

Abnormal Bleeding	Yes	No	Alcohol Abuse	Yes	No	Colitis	Yes	No	Cosmetic Surgery	Yes	No
Heart Surgery	Yes	No	Osteoporosis	Yes	No						

Medications:

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

Physician Name: _____ Physician Phone # _____
Pharmacy Name: _____ Pharmacy Phone # _____

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, as the health problems that I may have or the medication that I may be taking could have an important interrelationship with the dental treatment. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

AEGIS DENTAL
4125 FAIRWAY DR. SUITE 100. CARROLLTON. TX 75010
972 492 6700

FINANCIAL AGREEMENT

Thank you for choosing AEGIS DENTAL for you and/ or your family's dental care! We are committed to your dental treatment being a success. Please understand that payment of your bill is considered a part of your treatment and makes it possible for us to remain a viable dental practice. Please read this form carefully and initial next to each point. A signed financial agreement is required prior to any treatment. If you have any questions, please do not hesitate to ask.

____ 1. Payment for treatment is due at the time of services rendered. For minors, the parent or guardian bringing the child to the visit is responsible for all charges incurred. We accept Cash, Visa, MasterCard American Express and Discover. We are also pleased to offer Care Credit, which offers NO Interest and Low interest payment plans.

____ 2. It is necessary to provide all the information necessary to file dental claims on your behalf. This will include the insured's personal information, a valid Driver's license, and a valid Dental insurance card; with a phone number to verify benefits and a correct mailing address. If this information is not available at the time of the appointment or the insurance company cannot confirm eligibility, you will be responsible for payment in full at the time treatment is provided.

____3. As a courtesy, we will submit a claim to your dental insurance for benefits. Please understand your insurance benefits are a contract between you and your employer. We will estimate your copay based on information we obtain from your insurance company. On each visit to the office you will be responsible for deductibles, co-payments, and/ or balances not covered by your insurance.

____ 4. Missed Appointment Policy: Your appointment time is reserved just for you; if you cannot keep your appointment. Please give us a 2-day notice so that another patient may have your appointment time. There will be a $25 no-show/cancellation charge if you do not notify the office of your missed or cancelled appointment. If you are more than 15min. late, we consider this a missed appointment and the fee may be charged.

____ 5. No personal checks accepted

I acknowledge and accept full financial responsibility for all charges for services or items provided to myself and family. I understand any insurance estimate given by this office is not a guarantee of actual insurance payment or coverage. I understand that filing a claim with my insurance benefit plan does not relieve me from my responsibility for the payment of all charges.

I assign dental benefits to be paid directly to MOJI CHANDY DDS PLLC.

We thank you for your cooperation in our financial policy.

I have read and accept the above financial policy, understand it and agree to the terms.

Name of Patient/ Legal Guardian _____ Date: _____

Signature of Patient/ Legal Guardian _____ Date: _____

AEGIS DENTAL
4125 FAIRWAY DR. SUITE # 100. CARROLLTON. TX – 75010
972 492 6700

Notice of Privacy Practices Acknowledgement

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 among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* regarding the description of the uses and disclosures of my protected health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient / Legal Guardian Name: _____ Relationship: _____

Signature: _____ Date: _____

Please tell how you heard about AEGIS DENTAL.

Internet _____ Direct Mail _____ Magazine _____ Personal Referral _____

Other _____