InStyle Dental
Patient Registration

Date: _____
First Name: _____ Middle Initial: ____ Last Name: _____
Date of Birth: _____ Age: _____ Sex: Male Female
Address: _____ City: _____
State: _____ Zip: _____ Email Address: _____
Cell Phone: _____ Home Phone: _____ Work Phone: _____
Employed by: _____ Occupation: _____
Emergency Contact Name: _____ Emergency Contact Phone #: _____

How did you hear from us? **Please Circle** Google Computer-Internet Phone-Internet Phone-Text Phone App Tablet-Internet Facebook Walk-By Referred from a Friend/Family Dental Insurance Provider Employer ZocDoc Community-Outreach
Other? _____

Account Information of Responsible Party

Responsible Party (Who is financially responsible for this account?) _____
Relationship to Patient: Self ____ Spouse_____ Parent_____ Other _____
Date of Birth: _____ Social Security: _____ Driver's License and State: _____
Address: _____ City: _____
State: _____ Zip: _____ Email Address: _____
Cell Phone: _____ Home Phone: _____ Work Phone: _____
Employed By: _____ Occupation: _____
Employer's Address: _____ City: _____
State: _____ Zip: _____ Employer's Phone #: _____

Primary Insurance Company: _____ Effective Date: _____
Name of Subscriber: _____ DOB: ___/___/___ SSN: ____-____-____Relation to patient: _____
Policy / ID #: _____ Group #: _____

Secondary Insurance Company: _____ Effective Date: _____
Name of Subscriber: _____ DOB: ___/___/___ SSN: ____-___-____ Relation to patient: _____
Policy / ID #: _____ Group #: _____

Dental History

Reason for today's visit? (example: checkup, cleaning, pain): _____
Previous Dentist? _____ City: _____ State: _____
Last visit to previous dentist? _____
Reason for changing dentist? _____
When was your last dental cleaning? _____
How often does patient brush your teeth? _____ Floss? _____
Is patient nervous about seeing a dentist? No____ Yes ____ (why?) _____
Does the gums bleed easily, feel tender, or irritated? No_____ Yes_____
Are teeth sensitive to hot, cold, or sweets? No _____ Yes_____
Any clicking or popping noises when opening and closing mouth?
Does patient grind or clench teeth? No _____ Yes _____
If so, is a night guard used? No _____ Yes _____
Interested in whiter teeth? No_____ Yes_____
Interested in straighter teeth? No _____ Yes_____
Other Comments or concerns? _____

Medical History

Physician's Name: _____ Clinic's Name: _____
Physician's Address: _____City: _____ State: _____ Zip: _____
Phone number of Physician or Clinic: _____ Fax: _____
Is the patient's health considered to be: Excellent _____ Good_____ Fair _____ Poor_____
Is Patient being treated by a physician now? No ____ Yes ____ (Explain)_____
_____
Allergic to any medicines? No_____ Yes _____ if so, which ones? _____
Allergic to Metals? No_____ Yes _____
Taking any Medication? No_____ Yes_____
List of Medications: _____
_____

Does the patient have any of the following, please check those that apply?

Heart Condition	Yes___No___	Stroke	Yes___No___	High Blood Pressure	Yes___No___
Diabetes Type__	Yes___No___	Rheumatic Fever	Yes___No___	Kidney/Liver Disorder	Yes___No___
Eye disorder	Yes___No___	Tumors	Yes___No___	Prolong Bleeding	Yes___No___
Tuberculosis	Yes___No___	Asthma	Yes___No___	Epilepsy	Yes___No___
Hepatitis Type __	Yes___No___	AIDS/HIV	Yes___No___	Radiation Therapy	Yes___No___
Venereal Disease	Yes___No___	Thyroid Condition	Yes___No___	Chemo Therapy	Yes___No___
Arthritis	Yes___No___	Birth Control Pills	Yes___No___	Stomach/ Intestinal Problems	Yes___No___
Heart Pacemaker	Yes___No___	Fainting/Dizzy Spells	Yes___No___	Artificial Heart Valve	Yes___No___
Heart Murmur	Yes___No___	Glaucoma	Yes___No___	Cold Sores/ Fever Blisters	Yes___No___
Latex Sensitivity	Yes__No___	Bruises Easily	Yes___No___	Takes Blood Thinners	Yes___No___
Ulcers	Yes___No___	Artificial Joints	Yes___No___	Prolong Bleeding Disorder	Yes___No___
Psychiatric care	Yes___No___	Psychological Care	Yes___No___	History of Drug Addiction	Yes___No___
Pregnant	Yes___No___	Herpes	Yes___No___	Take antibiotic prior to treatment	Yes___No___

Are there any other medical problems that we should be aware of? Yes _____ No _____ If yes, explain:
_____
_____

Disclosures and Consents

1. I understand that the above information is necessary to provide the patient with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the Doctor of any change in the patient' health or medication.
2. Upon such diagnosis, I authorize the Doctor to perform all recommended treatment mutually agreed upon by me to employ such assistance as required to provide proper care.
3. I hereby authorize direct payment of my insurance benefits to InStyle Dental or the physician individually for services rendered to me or my dependents by the physician. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that InStyle Dental is unable to collect from my insurance carrier for whatever reason. I understand that payment is due at the time of service unless other arrangements have been made prior to the services being rendered.
4. I authorize InStyle Dental to contact me via phone to discuss dental appointments, dental billing, and my dental insurance information.
5. I certify that I have received and read a copy of the HIPPA consent and disclosure policy. I hereby authorize InStyle Dental or the physician individually to release any of my or dependent's dental or incidental non-public personal information that may be necessary for dental evaluation, treatment, consultation, or the processing of dental insurance benefits.

Patient's Signature: _____ Date: _____
Parent/Responsible Party Signature: _____ Date: _____

InStyle Dental

HIPAA Disclosure & Consent

Patient's Name: _____ Date of Birth: _____ SSN: _____-_____-_____

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you or your dependents. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.
You have the right to request that we restrict how protected health information about your is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such revocation shall not affect any disclosures that InStyle Dental or any individual physician of InStyle Dental have already made in reliance on your prior Consent. The Practice provides this form to comply with **Health Insurance Portability and Accountability Act (HIPAA).**

The patient understands that:

- -Protected health information may be disclosed or used for treatment, payment, or health care operations.
- -The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- -The practice reserves the right to change the Notice of Privacy Practices.
- -The patient has the right to restrict the uses of their information but the Practice does not have to agree to the restrictions.
- -The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- -The Practice may condition receipt of treatment upon the execution of this Consent.
- -The patient acknowledges that he/she has received a copy of our HIPAA practices brochure.

List family members or other persons with whom we may discuss the patient's diagnosis and treatment:
Name _____ Phone _____
Name _____ Phone _____
Name _____ Phone _____

List where you would want to receive messages about billing, insurance questions, appointments, or any dental questions.
Phone Calls _____ Mailings _____ Emails _____ Text Messages_____ Other_____

May confidential messages be left to an assistant or family member? No_____ Yes_____

I authorize the release of my confidential protected dental information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be redisclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected dental information.

Print Name: _____ Signature: _____ Date: _____

(Do not fill out)
InStyle Dental Representative: _____ Date: _____

Client Rights and HIPAA Authorizations

The following specifies your rights about this authorization under the health insurance portability and accountability act , as amended from time to time (HIPAA).

1. Tell your provider if you do not understand this authorization, and the provider will explain it to you.
2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to provider at the following address (insert address of provider): 7863 Callaghan Rd Suite 201 San Antonio, TX 78229.
3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, payment, enrollment or your eligibility for benefits. However, you may be required to complete this authorization form before receiving treatment if you have authorized your provider to disclose information about you to a third party. If you refuse to sign this authorization, and you have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a patient tin their practice.
4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA. If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.
5. You may inspect or copy the protected dental information to be used or disclosed under this authorization. You do not have the right of access to the following protected dental information: psychotherapy notes, information compiled for legal proceedings, laboratory results to which the Clinical Laboratory Improvement ("CLIA") prohibits access, or information held by certain research laboratories. In addition, our provider may deny access if the provider reasonably believes access could cause harm to you or another individual. If access is denied, you may request to have a licensed health care professional for a second opinion at your expense.
6. If this office initiated this authorization, you MUST receive a copy of the signed authorization.
7. Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes. HIPPA provides special protections to certain medical records known as "Psychotherapy Notes." All Psychotherapy Notes recorded on any medium by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separate from the rest of the client's medical records to maintain a higher standard of protection. "Psychotherapy Notes" are defined under HIPAA as notes record by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separate from the rest of the individual's medical records. Excluded from the "Psychotherapy Notes" definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. Except for limited circumstances set forth in HIPAA, in order for a medical provider to release "Psychotherapy Notes" to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other dental records.
8. You have a right to an accounting of the disclosures of your protected dental information by provider or its business associates. The maximum disclosure accounting period is the six years immediately preceding the accounting request. The provider is not required to provide an accounting for disclosures: (a) for treatment, payment, or dental care operations; (b) to you or your personal representative; (c) for notification of or to persons involved in an individual's dental care or payment for dental care, for disaster relief, or for facility directories; (d) pursuant to an authorization; (e) of a limited data set; (f) for national security or intelligence purposes; (g) to correctional institutions or law enforcement officials for certain purposes regarding inmates or individuals in lawful custody; or (h) incident to otherwise permitted or required uses or disclosures. Accounting for disclosures to dental oversight agencies and law enforcement officials must be temporarily suspended on their written representation that an accounting would likely impede their activities.