

**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 #: \_\_\_\_\_

**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 \_\_\_\_\_

Jerit Davis, D.D.S.  
4685 Eldorado Parkway  
Suite 200  
Frisco, Texas 75034  
214-618-5450  
drdavis@jeritdavisdds.com

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**AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION**

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Patient name \_\_\_\_\_

Patient phone number (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Patient address \_\_\_\_\_

I, authorize the professional office of my dentist named above to release health information identifying me [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services] to other health professionals as needed to maintain my healthcare.

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. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

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.

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:

Relationship to Patient \_\_\_\_\_ Print Name \_\_\_\_\_

Source of Authority \_\_\_\_\_

Effective date of notice: 01-21-2007  
**NOTICE OF PRIVACY PRACTICES**

Jerit Davis, D.D.S.  
4685 Eldorado Parkway  
Suite 200  
Frisco, Texas 75034  
214-618-5450  
drdavis@jeritdavisdds.com

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**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.**

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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 treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

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 will refer to your file for a health information release form. If you do not have one on file, you will be contacted prior to the release of any information.

**USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION**

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;

disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;

disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;

uses or disclosures for health related research;

uses and disclosures to prevent a serious threat to health or safety;

uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;

disclosures of de-identified information;

disclosures relating to worker's compensation programs;

disclosures of a "limited data set" for research, public health, or health care operations;

incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;

disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

### **APPOINTMENT REMINDERS**

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

### **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. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours. 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. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this Notice.
- 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. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of

the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

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). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

## **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 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.

----- tear here -----

### **ACKNOWLEDGEMENT OF RECEIPT**

I acknowledge that I received a copy of Dr. Jerit Davis' Notice of Privacy Practices.

Patient name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

## DEPOSIT POLICY:

In an effort to serve patients in the most respectful manner possible, Dr. Davis and team do not double book appointments. Instead, time is reserved to provide individual dental treatment. We understand that you, the patient, expect us to arrive timely and predictably for your appointment and we must offer you the same respect. Our choice to not double book appointments is our effort to offer you, the patient, the respect and care you deserve. In the event that you, the patient, are asked to wait more than 15 minutes for a reserved appointment with Dr. Davis or team, a gift card will be delivered to you as a token of our appreciation for your understanding. We will always email or call you as a courtesy reminder and your confirmation can be a response to that contact. You may confirm your appointment by calling our office at (214) 618-5450 or by responding to our e-mail message and writing "confirm" in the message space.

Our patients may not realize how frequently appointments are disrespected or missed. However, in order to have the continued ability to avoid double booking appointments we have the following requests:

- For appointments 90 minutes or less a \$25 charge will be applied to the patients account unless 24 hours notice is given.
- For appointments 90 minutes or longer we request one of the following upon reserving a treatment appointment:
  - 1) A deposit equal to the amount of 25% of the patient's copayment not to exceed \$100.00. If no insurance is available to the patient, the deposit will equal 25% of the entire treatment scheduled up to \$100.00. Please note this deposit request is only for treatment already diagnosed and the deposit is due at the time the patient elects to schedule the treatment. The deposit is fully refundable as long as 24 hours notice is given for canceling or rescheduling the appointment reservation.

OR

- 2) A credit card authorization granting us permission to bill your credit card in the event that you do not honor your appointment reservation with 24 hours notice of a need to reschedule or cancel. This authorization form will grant us permission to charge an amount equal to 25% of the patient's copayment up to \$100.00. If no insurance is available to the patient, the charge will equal 25% of the entire treatment scheduled up to \$100.00. The credit card authorization is for one-time use only and will not be charged as long as 24 hours notice is given for canceling or rescheduling the appointment reservation.

We look forward to serving you and providing dental care to you and your family.

Dr. Davis & Team

## FINANCIAL ACCOUNTABILITY

Dear Patient,

Dr. Davis and his team believe strongly in the importance of excellent dental care and we strive to provide the best dental treatment available. Also, we are sensitive to the financial limitations that influence your choice of treatment. As you enter our practice, we want to assure you that we are flexible and caring in our approach to financing.

We work with most insurance companies and always try to maximize your coverage through meticulous detailing of procedures and interaction with your insurer. We even complete and file your claim forms and are available to answer any insurance related questions that may arise. If we are unable to answer your questions, we will certainly direct you toward the appropriate person at your insurance company. Please remember, however, that you are responsible for the portion of your treatment not covered by insurance. As a courtesy, we will file your insurance claim on your behalf. However, should your insurance company not render payment within 60 days, please be aware that you will personally be responsible for the account balance and we will direct all insurance inquiries and payment to you, the patient.

Under most insurance plans, patients are responsible for a portion of the financial investment related to their treatment. Should you find that your investment is more than you are comfortable delivering on your day of service, we have five financial options that can reduce your immediate out of pocket expense:

### 1) Care Credit

Care Credit is a Medical, Dental and Vision credit line that patients qualify for through our office. You make your account payments directly to Care Credit and can use your credit line in our office and any other medical, dental or vision practice that accepts the credit line. For your convenience, we can process your application here in our office and it is easy to qualify for - in fact, we have about 90% success rate in qualifying patients for the line of credit. In most cases, we can offer 0% interest! Using Care Credit, we are also able to lengthen the payments up to an 18 month time period.

### 2) Major Credit Cards

In order to supply our patients with several options, we accept all major credit cards including Visa, Mastercard, Discover and American Express.

### 3) Health Savings Accounts

For your convenience, our practice is prepared to process all major health saving debit or "credit" cards. If your health savings account does not provide you with a card to utilize in healthcare facilities, we will gladly provide you with a detailed list for your employer reimbursement.

4) In Office Financing

If you prefer to keep your payments “in house,” we have an option that allows such flexibility. You may split your investment into two monthly payments with your first payment due on the day we begin treatment and the second payment due one month later.

5) Discount

If you prefer to lower your overall personal investment and have the financial flexibility that allows you to make a larger payment, you may pay the full treatment plan amount prior to your appointment and be reimbursed directly by your insurance company, allowing you to receive a 5% "cash pay" discount.

Just as you do, we must balance our finances, therefore we ask that you either pay your portion of the bill or select one of the above payment options at the time of treatment. Our first priority is your dental care and we will work with you to select a method of payment that works for well for both of us.

We hope that you find this information useful. Rest assured that we are here to help make quality dental care obtainable for all. We look forward to working with you to achieve excellent dental health.

Sincerely,

Dr. Davis & Team

**ACKNOWLEDGEMENT OF RECEIPT**

I acknowledge that I have received a copy of Dr. Jerit Davis' Appointment Accountability and Financial Accountability and have asked any questions that I may have.

Patient Name \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_