Patient Registration Information

2200 South Morgan Street
Granbury, Texas 76048

Patient Information

Patient's Name: ______________________________________ (______________________)
Pref. Name

Mailing Address: ____
City: _________________________ State: ___________ Zip Code: ____________________

Date of Birth: _____________________ Social Security #:_______-_____-_________

Sex: ☐Male ☐Female Driver's License #: ________________State:_____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Long-term Partner

Cell #: __________________ Home #: __________________ Work #:________________

Email Address: ____

Is it okay for us to email you? ___Yes ___ No Is it okay for us to text you? ___Yes ___No

Preferred Pharmacy: ____

Responsible Party

Responsible Party (**If someone other than patient**): ____
Mailing Address: ____
City: _____________________________State: _____________ Zip Code: _______________
Social Security #: ________-_______-_______ Birthdate: ______________________________

Insurance Information

Policy Holder: _________________________ Relationship: ___________________________
Member Id #: ________________________ or Policy Holder SS#: ______________________
Group #:_____________________ Policy Holder Employer: ____________________________
Insurance Company: _______________________ Phone Number: ______________________

Emergency Contact

Emergency Contact: ___________________________ Phone #: ____________________
Relationship to patient: ________________________

How did you hear about our office? ____
If you were referred by someone, may we know who? ______________________________________

Thank you for choosing our office for your dental needs!

Adult _Children Medical History Form

Patient Name: Birth Date: Date Created:

Disclaimer

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 medications that you may be taking could have an important interrelationship with the dentistry you will receive. Your health is very important to Dr. McCoy, please answer the following questions as thoroughly as possible.

Question	Answer	
Are you under a physician's care now?	Yes No	If yes
Have you ever been hospitalized, had a major operation?	Yes No	If yes
Have you every had a serious hear or neck injury?	Yes No	If yes
Is fluoride taken in any form?	Yes No	If yes
Do you use tobacco, vapes or any other smoking products?	Yes No	If yes
Do you use controlled substances?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing Bisphosphonates?	Yes No	If yes
Are you currently taking any anticoagulants, such as: Eliquis, Coumadin, Xarelto, Aspirin?	Yes No	If yes
Do you have any artificial joints? Please list	Yes No	If yes
Are you currently taking any medications, including vitamins? Please List	Yes No	If yes

Do you have any Heart problems?

Artifical Heart Valve	Yes No	Congenital Heart Disorder	Yes No	Heart Pacemaker	Yes No
Mitral Valve Prolapse	Yes No	Heart Attack/ Failure	Yes No	Heart Murmur	Yes No

Please list any other heart conditions not included: Yes No If yes

Women: Are you...

- [ ] Pregnant?
- [ ] Trying to get pregnant?
- [ ] Nursing?

Are you allergic to any of the following?

Acrylic	Yes No	Aspirin	Yes No	Codeine	Yes No	Latex	Yes No
Local Anesthetics	Yes No	Metal	Yes No	Penicillin	Yes No	Sulfa Drugs	Yes No

Do you have any other allergies not listed? Yes No If yes

Question	Answer	
Have you ever been diagnosed as having gum disease? If yes, how long ago?	Yes No	If yes
How long has it been since your last cleaning?	Yes No	If yes

Question	Answer	
Do you like the appearance of your teeth or overall smile?	Yes No	If yes
Do you have spaces between your teeth that bother you?	Yes No	If yes
If your teeth are crooked or crowed, does that bother you?	Yes No	If yes
Do you like the color of your teeth?	Yes No	If yes
Do you like the size and shape of your teeth?	Yes No	If yes
Are you aware of clenching or grinding your teeth?	Yes No	If yes

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

Condition	Yes	No	Condition	Yes	No
Aids/HIV Positive	◯ Yes	◯ No	Alzheimer's Disease	◯ Yes	◯ No
Anaphylaxis	◯ Yes	◯ No	Anemia	◯ Yes	◯ No
Angina	◯ Yes	◯ No	Arthritis/Gout	◯ Yes	◯ No
Asthma	◯ Yes	◯ No	Blood Disease	◯ Yes	◯ No
Blood Transfusion	◯ Yes	◯ No	Breathing Problems	◯ Yes	◯ No
Bruise Easily	◯ Yes	◯ No	Cancer	◯ Yes	◯ No
Chemotherapy	◯ Yes	◯ No	Chest Pains	◯ Yes	◯ No
Cold Sores/ Fever Blisters	◯ Yes	◯ No	Convulsions	◯ Yes	◯ No
Cortisone Medicine	◯ Yes	◯ No	Diabetes	◯ Yes	◯ No
Drug Addiction	◯ Yes	◯ No	Easily Winded	◯ Yes	◯ No
Emphysema	◯ Yes	◯ No	Epilepsy or Seizures	◯ Yes	◯ No
Excessive Bleeding	◯ Yes	◯ No	Excessive Thirst	◯ Yes	◯ No
Fainting Spells/Dizziness	◯ Yes	◯ No	Frequent Cough	◯ Yes	◯ No
Frequent Diarrhea	◯ Yes	◯ No	Frequent Headaches	◯ Yes	◯ No
Genital herpes	◯ Yes	◯ No	Glaucoma	◯ Yes	◯ No
Hay Fever	◯ Yes	◯ No	Hemophilia	◯ Yes	◯ No
Hepatitis A	◯ Yes	◯ No	Hepatitis B or C	◯ Yes	◯ No
Herpes	◯ Yes	◯ No	High Blood Pressure	◯ Yes	◯ No
High Cholesterol	◯ Yes	◯ No	Hives or Rash	◯ Yes	◯ No
Hypoglcemia	◯ Yes	◯ No	Irregular Heartbeat	◯ Yes	◯ No
Kidney Problems	◯ Yes	◯ No	Leukemia	◯ Yes	◯ No
Liver Disease	◯ Yes	◯ No	Low Blood Pressure	◯ Yes	◯ No
Lung Disease	◯ Yes	◯ No	Osteoporosis	◯ Yes	◯ No
Pain in Jaw Joints	◯ Yes	◯ No	Parathyroid Disease	◯ Yes	◯ No
Radiation Treatments	◯ Yes	◯ No	Renal Dialysis	◯ Yes	◯ No
Rheumatic Fever	◯ Yes	◯ No	Rheumatism	◯ Yes	◯ No
Scarlet Fever	◯ Yes	◯ No	Shingles	◯ Yes	◯ No
Sickle Cell Disease	◯ Yes	◯ No	Sinus Trouble	◯ Yes	◯ No
Spina Bifida	◯ Yes	◯ No	Stomach/intestinal Disease	◯ Yes	◯ No
Stroke	◯ Yes	◯ No	Thyroid Disease	◯ Yes	◯ No
Tonsilitis	◯ Yes	◯ No	Tuberculosis	◯ Yes	◯ No
Tumors or Growths	◯ Yes	◯ No	Ulcers	◯ Yes	◯ No
Venereal Disease	◯ Yes	◯ No	Yellow Jaundice	◯ Yes	◯ No
Cerebral Palsey	◯ Yes	◯ No	Gag Reflex	◯ Yes	◯ No
Measles	◯ Yes	◯ No	Mumps	◯ Yes	◯ No
Hearing Problems	◯ Yes	◯ No	Recent Weight Loss	◯ Yes	◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

Signature of Patient, Parent or Guardian:

X Date:__________

Michael A. McCoy, DDS
2200 South Morgan St. Granbury, Texas 76048

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION
(This entire page must be completed)

Date authorization initiated: ____/____/____

Patient's name: ______________________________ **Date of birth:** __________________

Information to be Used or Disclosed:
My dental information relating to the following treatment or condition:
☐ Most recent _____ years of record
☐ My dental records for the following date(s):____________________________
☐ Entire dental record

Authorization to contact you:
Home: __________________________ May we leave a message YES/NO
Cell: ___________________________ May we leave a message YES/NO
Work: __________________________ May we leave a message YES/NO

Purpose of Use or Disclosure:
☐ Treatment, Payment or Health Care Operations
☐ Disclosure of Personal Information for Insurance Coverage Purposes
☐ Release of X-ray Records to different provider

To the Following Family Members: ____
Health Care Providers: ____

This Authorization will: ☐not expire or ☐expires on ___/___/___

Authorization and Signature: **To complete our office's compliance with the HIPAA policies it is necessary to have written permission to disclose patient information to your insurance company, individuals or agencies of your choice. Patient information may be disclosed without patient authorization to federal, state, and other oversight activities; public health activities and emergencies; judicial and administrative proceedings; and to a law enforcement official with a warrant or subpoena.** 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 re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected dental information.

Signature of patient: ____
Relationship to patient if Personal Representative: ____

Michael A. McCoy, D.D.S.
2200 South Morgan St.
Granbury, TX 76048

FINANCIAL ARRANGEMENTS AND DENTAL INSURANCE

(Please read carefully)

WE ARE NOT CONTRACTED PROVIDERS FOR ANY INSURANCE COMPANY.

We are committed to providing you with the best possible care. If you have dental insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our office policy.

Payment for ALL services is due at the time of service unless payment arrangements have been made in advance. Our office does not have a long-term payment plan. We accept cash, checks, Mastercard, Visa, and Discover. In special instances we may accept insurance assignment of benefits but we require a completed insurance form be presented at the first office visit. If the insurance claim has not been paid within 45 days it will then become your responsibility to pay the account in full.

Returned checks and balances older than 30 days may be subject to additional collection fees and interest charges of 12% per annum. Charges may also be made for broken or cancelled appointments without a 24 hour notice. A $25.00 an hour fee will be charged to your account for missed appointments**. PARENTS: Co-pays for any services for dependents are due on date of service. Treatment plans are provided prior to appointments with estimated co-pays. If needed, a prior arrangement with a parent needs to be taken care of before the child's appointment. Copays need to be paid in full at or before the child's appointment.**

We will gladly discuss your proposed treatment and answer any questions relating to our policy. You must realize however that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
2. Not all services are a covered benefit in all contracts; every plan differs. Some insurance companies arbitrarily select certain services they will not cover. The responsibility of knowing the coverage of your policy is yours and not ours.

We must emphasize that as dental care providers, our relationship is with you, NOT your insurance company. While filing of insurance is a COURTESY that we extend to our patients, all charges are your responsibility from the date the services are rendered. We also realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact the office immediately for assistance. Non-payment of your bill will force us to turn your account over to a collection agency.

If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE don't hesitate to ask us. We are here to help you.

Signature____ Date: _______________