Michael McCoy, DDS

2200 South Morgan Street
Granbury, Texas 76048
817.573.3366

Patient Registration Information

Patient's Name: _____ (_____)
Preferred Name

Mailing Address: _____
City: _____ State: _____ Zip Code: _____
Cell #: _____ Home #: _____ Work #: _____
Email Address: _____
Date of Birth: _____ Social Security #: _____-_____-_____
Sex: ☐Male ☐Female Driver's License #: _____State: _____
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Long-term Partner
Preferred Pharmacy: _____

Responsible Party

Responsible Party Name: **(If someone other than self)**: _____
Mailing Address: _____
City: _____State: _____ Zip Code: _____
Social Security #: _____-_____-_____ Birthdate: _____

Insurance Information

Policy Holder: _____ Relationship: _____
Member Id or SS#: _____Policy Holder DOB: _____
Group #: _____ Employer: _____
Ins. Co: _____ Phone Number: _____

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 all your dental needs!

[redacted]

Michael A. McCoy, D.D.S

[redacted]

Adult _Children Medical History Form 2024

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.

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 head 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

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

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?

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 McCoy, DDS
2200 South Morgan Street
Granbury, Texas 76048

Financial Arrangements & Dental Insurance

Please Read Carefully

We are committed to providing you with the highest quality dental care and want to help you maximize your available dental insurance benefits. To accomplish this, we ask for your cooperation and understanding of our financial policies.

Please understand that we are not an in-network or contracted provider with every dental insurance company. We will gladly discuss your proposed treatment and answer any questions regarding your insurance or financial responsibilities. However, it is important to understand the following: Your dental insurance is a contract between you, your employer, and your insurance company. Our office is not a party to that contract.

Dental insurance plans vary, and not all services are covered under every policy. Some insurance companies may exclude certain procedures or limit coverage for specific services. Understanding your individual policy and its benefits is ultimately your responsibility. Our relationship is with you, the patient, not your insurance company. Although filing insurance claims is a courtesy we provide, you are ultimately responsible for all charges from the date services are rendered, regardless of your insurance coverage or reimbursement.

We understand that unexpected financial circumstances can sometimes make timely payments difficult. If you experience financial difficulties, please contact our office as soon as possible so we can discuss possible arrangements. Please be aware that accounts with unpaid balances may be referred to a collection agency. WE ARE HERE TO HELP! If you have any questions about our financial policies, treatment costs, or insurance coverage, please don't hesitate to ask. We are always happy to help clarify your benefits and answer your questions. Thank you for choosing our office and allowing us to be part of your dental care!

Payment Policy

Payment for **all services is due at the time of service**, unless prior payment arrangements have been made with our office. Please note that we do not offer long-term payment plans. We accept cash, checks, Care Credit, Mastercard, Visa, American Express, and Discover. **A 3.75% processing fee will be added to all credit and debit card payments. (Fee does not apply to cash or check.)** If your insurance company has not paid a submitted claim within 45 days, the remaining balance will become your responsibility and must be paid in full.

Returned checks and account balances more than 30 days past due may be subject to additional collection fees and interest charges of 8% per monthly billing statement. **Appointments canceled or missed without at least 24 hours' notice may be subject to a fee of $50 per scheduled hour.**

Parents & Dependent Patients

Copayments for all services provided to dependents are due on the date of service.

Treatment plans and estimated copayments are provided before scheduled appointments. If special payment arrangements are needed, they must be discussed and approved with our office before the child's appointment. **All copayments must be paid in full on or before the date of the child's appointment.**

Patient Acknowledgement

I have read and understand the financial arrangements and dental insurance policies outlined above. I understand that I am financially responsible for all services rendered, regardless of insurance coverage or payment.

Patient/Guardian Signature: _____

Date: _____

Michael A. McCoy, DDS
2200 South Morgan Street
Granbury, Texas 76048
817-573-3366

HIPAA & Notice of Privacy Practices

NOTICE OF PRIVACY PRACTICES

THIS NOTICE OF PRIVACY PRACTICES (THE "NOTICE") DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY. WE CONSIDER THE PRIVACY OF YOUR HEALTH INFORMATION OF PARAMOUNT IMPORTANCE.

OUR LEGAL DUTY

As a recipient of health care services, you have certain rights. To learn more about these rights, we suggest you visit: https://www.hhs.gov/hipaa/for-individuals/index.html. We are required by law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We will follow the privacy practices that are described in this Notice while it is in effect.

We reserve the right to change our privacy practices and the terms of this Notice at any time. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will make commercially reasonable efforts to change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

OUR USE AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you only as necessary for treatment, payment, and our healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Health Care Operations: We may use and disclose your health information in connection with our health care operations. Health care operations including without limitation, quality assessment and improvement activities, reviewing the competence or qualifications of Health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or health care operations, you may give us written authorization to use your health information or to

disclose it to anyone for any purpose. If you give us a written authorization, you may revoke it in writing at any time, although such revocation will not affect any use, or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we will not use or intentionally disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your health care or with payment for your health care, but only if you agree in writing that we may do so.

Persons Involved In Care: We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, concerning your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will (1) disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your health care and (2) use our professional judgment and experience with common practice to make reasonable inferences of your best interest in allowing third parties to pick up prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you may be a victim of abuse, neglect, domestic violence or a possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials' health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders.

PATIENT RIGHTS

Access: You have the right to review or obtain copies of your health information, with limited exceptions. You may request copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, health care operations and certain other activities, for the last 6years. We will provide such a list at no charge

upon your request once in any 12-month period. We reserve the right to charge you for requests of more than one per 12-month period.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location and provide a satisfactory explanation of how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Any such request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form upon your request.

QUESTIONS AND COMPLAINTS

To learn more about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may contact us using the contact information listed below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Acknowledgement: I hereby acknowledge that I have read and fully understand the contents of this document, and I have been given the opportunity to ask all questions.

*By signing below, I acknowledge that I have read and understand this practices Notice of Privacy Practices

Print Patient Name: _____

Patient Signature: _____ Date: ____/____/_____