William S. Nantz, D.D.S.

Patient Registration

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

First Name:________________________ Middle__________________ Last Name:____________________________________

Patient Is: ____Child ____Adult Sex: ____Male ____ Female Date of Birth:______________________________

Social Security # ______-______-_____ Driver License # ____________________

Single:_______ Married________ Widowed_______ Separated______ Divorced

Address:____________________________________ City ______________________________ State/Zip_____________________

Home Phone:______________________ Work Phone:__________________ Cell Phone:______________________________

If Child:

Student Status: ____ Full Time ____ Part - Time

Name of School/ College and Address: ____ Grade Level ________________

Who does child live with? _____ Mom ______ Dad ______ Both Parents ______ Others ___________________________

Mothers Name ____________________ Work # _______________Cell # __________________Home # __________________

Fathers Name ____________________ Work # ________________ Cell # __________________ Home# __________________

Other ___________________________ Work#_________________ Cell # __________________ Home # ___________________

If Adult:

Employment Status:______ Full Time ______ Part-Time

Employer Name/ Address ____ Position: ________________________________

Pharmacy Preferred? Name _______________________________________Street Location____________________________

Whom May we thank for referring you? ____

Dental Insurance Information

Insured's Name ____

Last Name First Name Middle

Relation to Patient________________________________ Date of Birth __________________SSN_______-______-______

Address____ Home #_______________________ Cell #_____________________

City ____ State_________________________ Zip _______________________

Employer Name / Address ____Employer #___________________________

Insurance Company ____ Phone #__________________________________

Address____ City/State/Zip _________________________________

Group- Policy/ Contract # ______________________________________ Member ID __________________________________

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Who is your Medical Doctor? Name: _____________________________________ Phone# _____________________________

In Event of Emergency:

Who should we contact? ____Relationship?____________________________

Phone Numbers: Home_______________________________ Work ____________________ Cell _________________________

PLEASE FILL OUT OTHER SIDE, THANKS............................

William Nantz, D.D.S

Medical History

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 a important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Have you been to the dentist in the last three years ? Yes___ No ___

Please Give Dentist name and phone number ____

when was your last cleaning/ x-rays?____

Are you under physician's care Yes___ No___ If Yes ____________________________

Have you ever been hospitalized/ Major operation? Yes___ No___ If Yes____________________________

____

Have you ever had a serious head/ neck injury? Yes___ No___ If Yes ____________________________

Are you taking any medication, pills, or drugs ? Yes ___ No___ If Yes ____________________________

____

____

Do you take, or have taken, Phen-fen or Redux? Yes___ No ___ If Yes ____________________________

Have you ever taken Fosamax, Boniva, Actonal or any other medications containing Bisohophonates? Yes___ No ___ If Yes ____________________________

Are you on a special diet? Yes ___ No ___

Do you use tobacco? Yes ___ No ___

<u>Women: Are you...</u>

Pregnant/ Trying to get pregnant Yes____ No____ If Yes how many weeks _______ Nursing? Yes____ No ____

Taking oral contraceptives? Yes____ No____ If Yes ____________________________

<u>Are you allergic to any of the following?</u>

__ Aspirin __ Penicillin __ Codeine __ Acrylic __ Metal __ Latex __ Sulfa Drugs __ Local Anesthetics

Other? ________________________

Do you use controlled substances? Yes ____ No _____ If Yes ________________________________

If you have one of the following please contact your physician for a medical clearance: Artificial Heart Valve, Artificial Joint, Cancer, Mitral Valve Prolapse, Transplant, Pacemaker, and/or Pregnant. You can have them fax it to 409-866-7498 please call if you have any questions.

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

AIDS/HIV POSITIVE	__ Yes __No	Hemophilia	__Yes __ No
Aizheimer's Disease	__ Yes __No	Hepatitis A	__ Yes __ No
Anaphylaxis	__ Yes __ No	Hepatitis B or C	__ Yes __ No
Anemia	__ Yes __ No	Herpes	__ Yes __No
Angina	__ Yes __ No	High Blood Pressure	__ Yes __ No
Arthritis/ Gout	__ Yes __ No	High Cholesterol	__ Yes __ No
Artificial Heart Valve	__ Yes __ No	Hives or Rash	__ Yes __ No
Artificial Joint	__ Yes __ No	Hypoglycemia	__ Yes __ No
Asthma	__ Yes __ No	Irregular Heartbeat	__ Yes __ No
Blood Disease	__ Yes __ No	Kidney Problems	__ Yes __ No
Blood Transfusion	__ Yes __No	Leukemia	__ Yes __ No
Breathing Problems	__ Yes __ No	Liver Disease	__ Yes __ No
Bruise Easily	__ Yes __ No	Low Blood Pressure	__ Yes __ No
Cancer	__ Yes __ No	Lung Disease	__ Yes __ No
Chemotherapy	__ Yes __ No	Mitral Valve Prolapes	__ Yes __ No
Chest Pains	__ Yes __ No	Osteoporosis	__ Yes __ No
Cold Sores/Fever Blisters	__ Yes __ No	Pain in Jaw Joints	__ Yes __ No
Congenital Heart Disorder	__ Yes __ No	Parathyroid Disease	__ Yes __ No
Convulsions	__ Yes __ No	Psychiatric Care	__ Yes __ No
Cortisone	__ Yes __ No	Radiation Treatments	__ Yes __ No
Diabetes	__ Yes __ No	Recent Weight Loss	__ Yes __ No
Drug Addiction	__ Yes __ No	Renal Dialysis	__ Yes __No
Easily Winded	__ Yes __ No	Rheumatism	__ Yes __ No
Emphysema	__ Yes __ No	Scarlet Fever	__ Yes __ No
Epilepsy or Seizures	__ Yes __ No	Shingles	__ Yes __ No
Excessive Bleeding	__ Yes __ No	Sickle Cell Disease	__ Yes __ No
Excessive Thirst	__ Yes __ No	Sinus Trouble	__ Yes __ No
Fainting Spells/Dizziness	__ Yes __ No	Spina Bifida	__ Yes __ No
Frequent Cough	__ Yes __ No	Stomach/Intestinal Disease	__ Yes __ No
Frequent Diarrhea(IBS/Crohn's)	__ Yes __ No	Stroke	__ Yes __ No
Frequent Headaches	__ Yes __ No	Swelling of Limbs	__ Yes __ No
Genital Herpes	__ Yes __ No	Thyroid Disease	__ Yes __ No
Glaucoma	__ Yes __ No	Tonsillitis	__ Yes __ No
Hay Fever	__ Yes __ No	Tuberculosis	__ Yes __ No
Heart Attack/Failure	__ Yes __ No	Tumors or Growths	__ Yes __ No
Heart Murmur	__ Yes __ No	Ulcers	__ Yes __ No
Heart Pacemaker	__ Yes __ No	Venereal Disease	__ Yes __ No
Heart Trouble/Disease	__ Yes __ No	Yellow Jaundice	__ Yes __ No

Have you ever had any serious illness not listed __ Yes __ No If Yes ________________________________

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.

____Date__________________________________

Signature of Patient, Parent or Guardian

William S. Nantz, D.D.S., Inc.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: ____

Address: ____

Telephone: ____________________ E-mail: _________________________________ Patient Number: __________________

SECTION B: TO THE PATIENT (PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of tour protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices., we will issue a revised Notice of Privacy Practices, which will contain the changes. Those may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

William S. Nantz DDS, Inc.
6790 Phelan Boulevard
Beaumont, Tx 77706
(409) 866-7498

Right to revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

SIGNATURE:

I, _________________________________, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment payment activities and health care operations.

Signature: ____________________________________ **Date**:__________________

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: ____

Relationship to Patient:____

William S. Nantz, D.D.S., Inc.

6790 Phelan Blvd.

Beaumont , Texas 77706

ACKNOWLEDGEMENT OF RECEIPT OF

NOTICE OF PRIVATE PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, ______________________________, have received a copy of this office's Notice of Privacy Practices.

______________________________ (Please Print Name)

____________________ (Date)

______________________________ (Signature)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

____

____

Our Financial Policy

Thank you for choosing us as your dental provider. The following is our Financial Policy. Our main concern is that you receive the proper and optimal treatments needed to restore your dental health. Therefore, if you have any questions or concerns about our payment policies, please do not hesitate to ask Dr. Nantz or the front desk personnel. We ask that all patients read our financial Policy as well as complete our Patient Information Form prior to seeing the doctor.

Payment for services is due at the time services are rendered. We accept cash, checks, and for your convenience, all major credit cards. We will be happy to help you process your insurance claim for your reimbursement as long as all insurance information is verified.

Please notify us immediately if there are changes in your insurance and personal information. Please initial by the following:

1. Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our relationship is with you, not your insurance company. __________

2. All charges are your responsibility whether your insurance company pays or not. Not all services are a covered benefit in all policies. ____________

3. Fees for these services, along with unpaid deductibles and co-payments are due at the time of treatment. Remember these fees are just an estimation. Insurance may pay more or less. ____________

4. Any unpaid balance after insurance claim is paid you are responsible to pay within 45 days with cash, check, or a major credit card. __________

5. Balances older than 45 days will be subject to additional collection fees and/or actions. _________

6. $35.00 Fee on all returned checks. _________

7. We are implementing a fee of $50.00 for missed appointments. 24 hour notice for cancellation is required. We reserve the right not to reschedule frequently missed appointments. Promptness is appreciated. _____________

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems so that we can assist you in the management of your account.

Again, thank you for choosing us as your dental provider. We appreciate your trust in us and we appreciate the opportunity to serve you.

____ (Signature)

_____/_____/______ (Date)

Record of Disclosures

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communications of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

Home Telephone

- ☐ OK to leave message with detailed information
- ☐ Leave message with call back number only
- ☐ OK to fax to this number

Written Communication

- ☐ OK to mail to my home address
- ☐ OK to mail to my work address

Other :

- ☐ Explain ___________________________

Work Telephone:

- ☐ Ok to leave message with detailed information
- ☐ Leave message with call back number only

_______________________________ _______________________

Signature of patient Date

_______________________________ _______________________

Print Name Birthdate