PATIENT REGISTRATION

ID:									
First Name:			Last Name:					M	iddle Initial:
Patient Is: Policy Holde	r Responsible	Party	Preferred Name:						
Responsible Party (if s	omeone other than th	he patient) -	E 9157A A 2000 000 V					119%	
First Name:			Last Name:					M	fiddle Initial:
Address:			Add	Iress 2:					
City, State, Zip:								Pager:	
Home Phone:	,	Work Phone:				Ext:	-	Cellular:	
Birth Date:		Soc Sec:				Driv	ers Lic:		
Responsible Party is also	a Policy Holder for P	Patient	Primary Insura	nce Policy Ho	older		Secondary I	nsurance Pol	icy Holder
Patient Information —									
Address:			Add	ress 2:					
City;			State / Zip:					Pager:	
fome Phone:	1	Work Phone:				Ext:		Cellular:	
Sex: Male	Female		Marital Status:	Married	Single	Divorced	H Separ	rated W	idowed
Birth Date:		Age:	S	Soc Sec:		Drive	ers Lic:		
E-mail:			3	I would lil	ke to receive con	respondences	via e-mail.		
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X

Dr. Clay Keith Dr. Paul Denson Eaglesoft Medical History

Birth Date:

Date Created:

Date:_

Patient Name:

Are you also a serious finance or a major operation? Yes No If yes Have you ever hard a serious finance or neck injury? Yes No If yes Do you take, or have you taken, Pren-Pen or Reduc? Yes No If yes Do you taken, Pren-Pen or Reduc? Yes No If yes Have you see' taken Posamas, Boniva, Actonal or any other medications postanting bisphosphorates? Are you on a special diet? Yes No If yes Do you use to basco? Pren on a special diet? Yes No If yes Women: Are you. Prenant/Tring to get pregnant? Norring? Taking oral costraceptive? Women: Are you. Prenant/Tring to get pregnant? Norring? Taking oral costraceptive? Are you have, or have you had, any of the following? AlDigit's Prentine And the mer's Disease Yes No Disbets Yes No Disbets Yes No Dispets Yes N			realitialid around your mo	utth, your mo	uth is a pa	art of your entire body. He	aith problems that	you may have, or medication tha	t you may	be tak
Have you ever had a serious head or neck injury? Yes No 1f yes Are you taken, or have you taken, Phen-Fen or Redux? Yes No 1f yes Have you ever taken Foseman, Sonive, Actonel or any other medication containing beginsphoremen? Yes No 1f yes Have you ever taken Foseman, Sonive, Actonel or any other medication containing beginsphoremen? Yes No 1f yes Are you an a special diet? Yes No 1f yes Or you use to bacco? Yes No 1f yes Nomen: Are you Pregnant/Trying to get pregnant? Nove is alregic to any of the following? Applie Penicillin Codeline Acrylic Hetal Latex Solfa Drugs Taking oral contraceptives? No you have, or have you had, any of the following? Applie Yes No 0 Dibetes Yes No 1f yes No you have, or have you had, any of the following? Alpheima's Disease Yes No 0 Dibetes Yes No 0 Dibetes Yes No 0 Hepatitis B or C Yes No Read Dialysis Yes No Angina Yes No Essily Winded Yes No Basily Winded Yes No Basily Winded Yes No Basily Winded Yes No Harps Arthridal HaertYalve Yes No Essily Winded Yes No Hills Blood Treastre. Solfa Drugs Taking oral contraceptives? No you have, or have you had, any of the following? Applie Yes No Dibetes Yes No No Penicullin Code Read Yes No No Read Dialysis Yes No Hepatitis B or C Yes No Read Dialysis Yes No Hepatitis B or C Yes No Read Dialysis Yes No Hepatitis B or C Yes No Read Dialysis Yes No Hepatitis B or C Yes No Read Dialysis Yes No Hepatitis B or C Yes No Read Dialysis Yes No Hepatitis A Yes No Scarlet Freer Yes No Read Dialysis Yes No Hepatitis A Yes No Scarlet Freer Yes No Read Dialysis Yes No Hepatitis B or C Yes No Read Dialysis Yes No Hepatitis B or C Yes No Read Dialysis Yes No Hepatitis B or C Yes No Scarlet Freer Yes No Hepatitis A Yes No Scarlet Freer Yes No Scarlet Freer Yes No Read Dialysis Yes No Hepatitis A Yes No Scarlet Freer Yes No Scarlet Freer Yes No Read Dialysis Yes No Hepatitis B Or Yes No Tropic Diases Ye	Are you under a physician's	s care now?	○ Ye	S () No	If yes					
Are you taken, p here-Fen or Redux? Yes No If yes Do you use containing bisphosphosphoxes? Are you an a special cliet? Yes No Do you use to bacco? Yes No Do you use controlled substances? Yes No Do you use controlled substances? No If yes Norman, Are you Pregnant/Trying to get pregnant? Applin Latex Do you use controlled substances? Nursing? Taking oral contraceptives? Taking oral contraceptives? To you salergic to any of the following? Applin Latex Sulfa Drugs Local Anesthetics Do you use, or have you had, any of the following? Applin Latex Sulfa Drugs Local Anesthetics Total Codeline Acrylic Local Anesthetics Local Anesthetics Do you use, or have you had, any of the following? Albelman's Disease Yes No Do Drug Addiction Yes No Emphysema Yes No Arthribis/Gout Yes No Frequent Headaches Yes No Recent Weight Loss Yes No Remail Dilaysis Yes No Emphysema Yes No Arthribis/Gout Yes No Emphysema Arthribis/Gout Yes No Frequent Headaches Yes No Frequent Headaches Yes No Frequent Headaches Yes No Frequent Diarhea Yes No Frequent Diarhea Yes No Frequent Diarhea Yes No High Blood Pressure Yes No Sinus Trooble Yes No Sinus Trooble Yes No Sinus Trooble Yes No Sinus Trooble Yes No Convolutions Yes No Tubercolosis Yes No Cold Sores/Feer Bilatos Yes No Heart Attack/Failure Yes No Parthrivold Disease Yes No Heart Torooble/Disease Yes No Parthrivold Disease Yes No Venereal Disease Yes No Cold Sores/Feer Bilatos Yes No Heart Trooble/Disease Yes No Paychistric Core Yes No Venereal Disease Yes	Have you ever been hospitalized or had a major operation?		ajor operation? O Ye	s ⊜ No	If yes					
Are you taking any medications, pills, or drugs? Yes No If yes Do you take, or have you take, Phen-Fen or Reduck? Yes No If yes Make you are retaken Fosamasy, Boniva, Actorel or any other Wes No If yes Are you on a special dies? Yes No Do you use ontroiled substances? Yes No Do you use controiled substances? Yes No Do you use controiled substances? No No Metal Catex Sulfa Drugs Codeine Acrylic Latex Sulfa Drugs Codeine Acrylic Appirior Metal Latex Sulfa Drugs Codeine Acrylic Local Anesthetics Other? Albelmar's Disease Yes No Diabetes Yes No Anaphylaide Yes No Drug Addiction Yes No Anaphylaide Yes No Emphysema Yes No Arthritis/Gout Yes No Recessive Trient Yes No Arthritis/Gout Yes No Frequent Codein Yes No Frequent Code Yes No Recessive Trient Yes No Recessive Trient Yes No Remail Dialysis Yes No Arthritis/Gout Yes No Frequent Code Yes No Recessive Trient Yes No Remail Dialysis Yes No Arthritis/Gout Yes No Frequent Code Yes No Recessive Trient Yes No Arthritis/Gout Yes No Frequent Code Yes No Recessive Trient Yes No Remail Dialysis Yes No Replication Yes No Replication Yes No Replication Yes No Single Cell Disease Yes No Single Cell Disease Yes No Remail Dialysis Yes No Replication Y	Have you ever had a serious head or neck injury?		jury? ⊜ ve	. ○ No	Ifves					
Do you take, or have you taken, Phen-Fen or Redux? Yes No If yes No If yes New you are taken Possman, Boniva, Actonel or any other medications containing bisphosphorores?	Are you taking any medicat	ions, pills, or drug			1-50/5712					
Have you ever taken Fosamas, Boniva, Actonel or any other medications containing bisphosphorases? Ves No Do you use to bacco? Ves No Do you use controlled substances? Ves No Doyou use controlled substances? Ves No Doyou use controlled substances? Nursing? Taking oral contraceptives? Taking oral contraceptives? Ves No Trying to get pregnant? Nursing? Taking oral contraceptives? Taking oral contraceptives? Ves No Apprinc Metal Latex Sulfa Drugs Taking oral contraceptives? Trying to get pregnant? Ves No Codeline Accylic Sulfa Drugs Local Anesthetics Coher? If yes Ves No Albehmer's Disease Ves No Cottisone Medidne Ves No Albehmer's Disease Ves No Disabets Ves No Anaphylade Ves No Disabets Ves No Disabets Ves No Anaphylade Ves No Disabets Ves No Disabets Ves No Anaphylade Ves No Disabets Ves No Disabets Ves No Anaphylade Ves No Disabets Ves No						-				
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Do you use to bacco? Yes No If yes	medications containing bis	phosphorates?	0.16		11 703					
De you use controlled substances? Ves No If yes Commit Are you Pregnant/Trying to get pregnant? Noursing? Taking oral contraceptives? Aspirin			○ Ye	S ○ No						
Taking oral contraceptives Taking oral contraceptives	Do you use tobacco?		○ Ye	○ No						
Pregnant/Trying to get pregnant? Nursing? Codeine Acrylic	Do you use controlled subs	tances?	○ Ye	: ○ No	Ifyes					
re you allergic to any of the following? Aspire Penicillin	/omen: Are you									
Aspiran	Pregnant/Trying to get p	pregnant?	Nurs	ing?			Taking	ral contraceptives?		
Metal Latex Sulfa Drugs Local Anesthetics Other?	e you allergic to any of the	following?								
Other?	Aspirin		Penicillin			Codeine		Acrylic		
o you have, or have you had, any of the following? AIDS/HIV Positive Yes No Diabetes Yes No Hemophilis Yes No Recent Weight Loss Yes Analyhidades Yes No Drug Addiction Yes No Hepatitis B or C Yes No Recent Weight Loss Yes Analyhidades Yes No Drug Addiction Yes No Hepatitis B or C Yes No Recent Weight Loss Yes Analyhidades Yes No Easily Winded Yes No Hepatitis B or C Yes No Recent Weight Loss Yes Analyhidades Yes No Easily Winded Yes No Hepatitis B or C Yes No Recent Weight Loss Yes No Analyhidades Yes No Easily Winded Yes No Hepatitis B or C Yes No Recent Weight Loss Yes No Analyhidades Yes No Easily Winded Yes No Hepatitis B or C Yes No Recent Weight Loss Yes No Analyhidades Yes No Recent Weight Loss Yes No R	_ Metal		Latex			Sulfa Drugs		Local Anesthetics		
AIDS/HIV Positive Yes No Alzheimer's Disease Yes No Diabetes No Diabetes No Diabetes No Diabetes No Diabetes Yes No Diabetes No Diabetes No Diabetes No Diabetes No Diabetes Yes No Diabetes No Diabetes No Diabetes No Diabetes No Diabetes Yes No Diabetes No Diabetes No Diabetes No Diabetes No Diabetes N	Other?				If yes					
Alzhelmer's Disease	o you have, or have you had	f, any of the follow	ring?							
Anaphylaxis				○ Yes	○ No	Hemophila	○ Yes ○ N	Radiation Treatments	① Yes	ON
Anemia	Alzheimer's Disease	O Yes O No	Diabetes	○ Yes	○ No	Hepatitis A	○ Yes ○ N	Recent Weight Loss	○ Yes	ON
Angina	Anaphylaxis	○ Yes ○ No	Drug Addiction	() Yes	○ No	Hepatitis B or C	○ Yes ○ N	Renal Dialysis	() Yes	ON
Arthritis/Gout Yes No Epilepsy or Seizures Yes No High Cholesterol Yes No Scarlet Fever Yes Arthritis/Gout Yes No Excessive Bleeding Yes No Hives or Rash Yes No Shingles Yes Arthritis/Gout Yes No Excessive Bleeding Yes No Hives or Rash Yes No Shingles Yes Arthritis/Gout Yes No Excessive Thirst Yes No Hypoglycemia Yes No Sickle Cell Disease Yes Asthma Yes No Fainting Spells/Dizziness Yes No Irregular Heartbeat Yes No Sinus Trouble Yes Blood Disease Yes No Frequent Cough Yes No Kidney Problems Yes No Spina Biffida Yes Blood Transfusion Yes No Frequent Diarrhea Yes No Leukemia Yes No Stomach/Intestinel Disease Yes Bruise Easily Yes No Genital Herpes Yes No Low Blood Pressure Yes No Swelling of Limbs Yes Problems Yes No Glaucoma Yes No Lung Disease Yes No Thyroid Disease Yes Chemotherapy Yes No Heart Attack/Failure Yes No Osteoporosis Yes No Tuberculosis Yes Cold Sores/Fever Blistors Yes No Heart Murmur Yes No Parin in Jaw Joints Yes No Ulcers Yes No Convulsions Yes No Heart Pacemaker Yes No Psychiatric Care Yes No Venereal Disease Yes Yes No Convulsions Yes No Heart Trouble/Disease Yes No Psychiatric Care Yes No Venereal Disease Yes Yes No Venereal Disease Yes No Yes Yes No Convulsions Yes No Heart Trouble/Disease Yes No Psychiatric Care Yes No Venereal Disease Yes Yes Yes	Anemia	O Yes O No	Easily Winded	() Yes	O No	Herpes	○ Yes ○ N	Rheumatic Fever	O Yes	ON
Artificial HeartValve	Angina	○ Yes ○ No	Emphysema	() Yes	○ No	High Blood Pressure	○ Yes ○ N	Rheumatism	() Yes	ON
Artifidal Joint	Arthritis/Gout	○ Yes ○ No	Epilepsy or Seizures	○ Yes	○ No	High Cholesterol	○ Yes ○ N	Scarlet Fever		
Asthma	Artificial Heart Valve	○ Yes ○ No	Excessive Bleeding	○ Yes	○ No	Hives or Rash	○ Yes ○ N	Shingles	○ Yes	ON
Blood Disease	ArtificialJoint	○ Yes ○ No	Excessive Thirst	○ Yes	○ No	Hypoglycemia	○ Yes ○ N	Sickle Cell Disease	○ Yes	ON
Blood Transfusion Yes No Frequent Diarrhea Yes No Leukemia Yes No Stomach/Intestinal Disease Yes Bruise Easily Yes No Genital Herpes Yes No Low Blood Pressure Yes No Swelling of Limbs Yes Cancer Yes No Glaucoma Yes No Lung Disease Yes No Thyroid Disease Yes No Chemotherapy Yes No Hay Fever Yes No Mitral Valve Prolapse Yes No Tonsillitis Yes Chest Pains Yes No Heart Attack/Failure Yes No Pain in Jaw Joints Yes No Ulcers Yes No Convulsions Yes No Heart Trouble/Disease Yes No Psychiatric Care Yes No Venereal Disease Yes Yes Yes No Venereal Disease Yes Yes Yes No Yes No Venereal Disease Yes Yes Yes Yes Yes No Venereal Disease Yes Yes Yes Yes Yes Yes Yes No Venereal Disease Yes Yes Yes Yes Yes Yes Yes No Venereal Disease Yes Yes Yes Yes Yes Yes Yes Yes Yes Y	Asthma	○ Yes ○ No	Fainting Spells/Dizzines	S ○ Yes	○ No	Irregular Heartbeat	○Yes ○N	Sinus Trouble	○ Yes	ON
Breathing Problems	Blood Disease	O Yes O No	Frequent Cough	○ Yes	○ No	Kidney Problems	○ Yes ○ N	Spina Bifida	() Yes	ON
Bruise Easily Yes No Genital Herpes Yes No Low Blood Pressure Yes No Swelling of Limbs Yes Cancer Yes No Glaucoma Yes No Lung Disease Yes No Thyroid Disease Yes Chemotherapy Yes No Hay Fever Yes No Mitral Valve Prolapse Yes No Tonsillitis Yes Chest Pains Yes No Heart Attack/Failure Yes No Osteoporosis Yes No Tuberculosis Yes Cold Sores/Fever Blistars Yes No Heart Murmur Yes No Pain in Jaw Joints Yes No Tumors or Growths Yes Conyulsions Yes No Heart Trouble/Disease Yes No Psychiatric Care Yes No Venereal Disease Yes	Blood Transfusion	○ Yes ○ No	Frequent Diarrhea	○ Yes	○ No	Leukemia	○ Yes ○ N	Stomach/Intestinal Disease	() Yes	ON
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Chest Pains Yes No Heart Attack/Failure Yes No Osteoporosis Yes No Tuberculosis Yes Cold Sores/Fever Blisters Yes No Heart Murmur Yes No Pain in Jaw Joints Yes No Tumors or Growths Yes Congenital Heart Disorder Yes No Heart Trouble/Disease Yes No Psychiatric Care Yes No Venereal Disease Yes	Cancer	○ Yes ○ No	Glaucoma	○ Yes	○ No	Lung Disease	3 8	12 72	_	
Cold Sores/Fever Blisters Yes No Heart Murmur Yes No Pain in Jaw Joints Yes No Tumors or Growths Yes Congenital Heart Disorder Yes No Heart Pacemaker Yes No Parathyroid Disease Yes No Venereal Disease Yes Yes	Chemotherapy	○ Yes ○ No	Hay Fever	○ Yes	○ No	Mitral Valve Prolapse	○Yes ○N	Tonsillitis	○ Yes	ON
Congenital Heart Disorder	Chest Pains	○ Yes ○ No	Heart Attack/Failure	() Yes	○ No	Osteoporosis	○ Yes ○ N	Tuberculosis	○ Yes	ON
Convulsions	Cold Sores/Fever Blisters	○ Yes ○ No	Heart Murmur	○ Yes	○ No	Pain in Jaw Joints	○ Yes ○ N	Tumors or Growths	○ Yes	ON
	Congenital Heart Disorder	○ Yes ○ No	Heart Pacemaker	O Yes	○ No	Parathyroid Disease	○ Yes ○ No	Ulcers	-	14-7
Yellow Jaundice Yes	Convulsions	○ Yes ○ No	Heart Trouble/Disease	○ Yes	○ No	Psychiatric Care	○ Yes ○ N	Venereal Disease	O Yes	ON
								YellowJaundice	○ Yes	O N
Have you ever had any serious illness not listed above? Oyes ONo If yes	Have you ever had any serio	ous illness not list	ed above?	CAN	16 year					92
Have you ever had any serious illness not listed above? Yes No If yes	and and and are		O YE	ONO	11 yes					
omments:	omments:									

B. CLAY KEITH, D.D.S., P.A. PAUL S. DENSON, D.D.S.

FINANCIAL POLICY

Thank you for choosing us as your dental care provider. We are committed to providing you excellent care and payment of your bill is part of successful treatment. Please read our Financial Policy and acknowledge your agreement with your signature and date below.

*****Regarding Insurance*****

As a service to our patients we will prepare and submit your insurance claim form. At the time of your appointment, you will be expected to pay your deductible as well as any portion of the treatment fees that we estimate will not be covered by your insurance policy. Because of insurance policy changes and/or necessary changes in treatment plans, your dental coverage may vary from this estimated treatment

calculation. Please be aware that our estimate for your treatment is that: an Estimate.

**There may be a balance on your account after insurance pays, for which you are responsible.

Our office will submit your claim to your insurance company twice if necessary. Additional submissions are the patient's responsibility. If your insurance company has not paid the full balance of the claim within 60 days from treatment date, you will be responsible for paying the balance. Please remember that your insurance is a contract between you and your insurance company. Our office is not part of the contract.

**In the event that SECONDARY INSURANCE is effective, it will be the responsibility of the patient to file for secondary benefits to get reimbursed directly, as our office will ONLY file PRIMARY COVERAGE.

In the event that MEDICAL INSURANCE or WORKERS COMP. needs to be filed, it will be the responsibility of the patient to pay up front for all treatment and then we will assist in filing.

Accounts

A finance charge of 1.5% per month may be assessed to accounts with balances outstanding for 60 days from treatment date. This FINANCE CHARGE represents an ANNUAL PERCENTAGE RATE OF 18%. In the event of non-payment, the patient or responsible party agrees to pay all the costs of collection including but not limited to attorney fees, court costs, collection agency fees, etc. If your check is dishonored or returned, for any reason, you will be charged an additional \$30 processing fee.

Minor Patients

The adult accompanying a minor and/or parent or guardian is responsible for payment of deductibles or any co-pays at the time of service. Any arrangements between ex-spouses for payment needs to be handled between them. Our office will not bill separately in those cases.

Missed Reservations

No charge will be made for rescheduling an appointment provided **24 hours notice is given**. Otherwise, a minimum **charge of \$50** (per 1/2 hour missed) will be charged. Once an appointment has been made, please remember this time has been specifically reserved for you. The missed appointment fee is not a covered expense of your insurance company.

I have read and understand the financial policy of this practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

Signature of Patient/Parent/Guardian	Date	

Effective date of notice: JANUARY 1, 2013 NOTICE OF PRIVACY PRACTICES

THE CENTER FOR IMPLANT AND GENERAL DENSTISTRY 408 EAGLE SPIRIT DRIVE, LINDALE, TX 75771

903-882-6141 FAX: 903-882-3558

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.

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 usually will not ask you for special written permission.

We will ask for special written permission in the following situations: using your photos on our Facebook page, our website, or for advertising purposes.

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, text, write or email to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also 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, cell phone 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 website.

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,

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of The Center F Practices.	e of Privacy	
Patient name		
Signature	Date	(*)