PATIENT REGISTRATION INFORMATION

Patients Name ☐ Single ☐ Married ☐ Life Partner ☐ Divorced ☐ Separated ☐ Widowed

Social Security # | Date of Birth | Cell Phone | Home Phone | Business Phone

Address | City | State | Zip

Employed By | Email Address

Spouse/Partner's Name | Social Security # | Date of Birth

Spouse/Partner's employed by

Best Form of Contact?

☐ Home ☐ Work
☐ Cell ☐ Email

EMERGENCY CONTACT/NEAREST RELATIVE

Name | Phone

Address | City | State | Zip

DENTAL INSURANCE

Name of Dental Insurance | Group Number | Member ID #

Spouse/Partner's Dental Insurance | Group Number | Member ID #

PARTY RESPONSIBLE FOR PAYMENT:

Check all that applies for Payment: ☐ Cash ☐ Check ☐ Credit Card ☐ Care Credit

Referred By | Address

Due to the increased cost of mailing statements and in trying to keep our fees as low as possible, we find it necessary to expect our patients to pay for service at the time they are rendered, unless prior arrangements have been made by our receptionist or business assistant. Until arrangements are made, we will expect payment each time we see you. We want to give you the best and most reasonable service possible without having to raise our fees and will appreciate your cooperation in this matter.

I FULLY UNDERSTAND AND AGREE TO THE ABOVE POLICY.

Patient Signature | Date

HEALTH HISTORY

FOR YOUR WELFARE AND OUR EFFICIENCY OF DIAGNOSIS AND TREATMENT, PLEASE FILL IN THE FOLLOWING *CONFIDENTIAL* FORM COMPLETELY, PLEASE ANSWER ALL QUESTIONS.

Name: ____________________ Name of Physician: ____________________

Date of Birth: ____________________ Age: ____________________

☐ High Blood Pressure	☐ Diabetes	☐ Mitral Valve Prolapse	☐ Stomach Ulcer
☐ Any Heart Problems	☐ Epilepsy	☐ Emphysema	☐ Nervous Problems
☐ Rheumatic Fever	☐ Hepatitis or Liver Disease	☐ Arthritis	☐ Psychiatric Care
☐ Low Blood Pressure	☐ Kidney Problems	☐ Glaucoma	☐ Asthma or Hay Fever
☐ Circulatory Problems	☐ Night Sweats	☐ Mouth Ulcers	☐ Radiation/Xray Treatment
☐ Stroke	☐ Tuberculosis	☐ Anemia	☐ Joint Replacement Surgery
☐ Cancer or Tumor	☐ Hormone Disorder	☐ Sinus Problems	☐ Other

1. **HOW IS YOUR GENERAL HEALTH?** ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR
2. Do you have or have you had any of the following, please indicate with check mark.
3. Are you being treated by a physician now? ☐ YES ☐ NO
   If yes, please give reason for treatment ____________________
   ____
4. Are you allergic to Latex Penicillin, Codeine or aspirin? ☐ YES ☐ NO
5. Are you subject to prolonged or excess bleeding? ☐ YES ☐ NO
6. Females: Are you pregnant? ☐ YES ☐ NO
7. What types of medications are you taking? ____________________
   For what purpose? ____________________
8. Have you had any serious illness or operation in the last 5 years? ☐ YES ☐ NO
9. Approximate date of last dental visit? ____________________
10. Approximate date when teeth were last cleaned? ____________________
11. How often do you floss your teeth? ____________________
12. Do your gums ever bleed while brushing? ☐ YES ☐ NO
13. Does food catch between your teeth? ☐ YES ☐ NO
14. Do your gums ever feel tender or swollen? ☐ YES ☐ NO
15. Does heat, cold, or sweets cause pain in your mouth? ☐ YES ☐ NO
16. Do you clench your teeth during the day or night? ☐ YES ☐ NO
17. Have you ever been treated for "Trench Mouth" or Gum Disease? ☐ YES ☐ NO
18. Have you ever had Periodontal Treatments or Gum Surgery? ☐ YES ☐ NO
19. Have you had any DIFFICULT extractions in the past? ☐ YES ☐ NO
20. Have you lost any teeth? ☐ YES ☐ NO
21. Have they ever been replaced by: ☐ Fixed Bridge ☐ Removable Partial Denture ☐ Implant
22. Do you have any other disease, condition or problem not listed above that you think I should know about?

____

____

____________________ DATE

____________________ SIGNATURE

Dr. Donald G. Nield

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name:____

Address:______________________________________

Phone: ____________________ Email:_________________________

Social Security #: ________________________ Date of Birth: __________

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 your 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 changes may apply to any of your protected, 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:

Contact Person:____________________________________

Phone: ____________________ Fax: ____________________

Address: ____

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 the 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.

Right to Revoke:

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.

Sign: __________________________

Date: __________

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

Personal Representative’s Name:____________________________

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include completed Consent in the patients chart.

DONALD G. NIELD, D.M.D.
GENERAL & COSMETIC DENTISTRY

5818 Babcock At Huebner * Babcock Square
San Antonio, TX 78240 * (210) 696-2389

AUTHORIZATION/RESPONSIBILITY AGREEMENT

* *Patients who have dental insurance coverage please sign this section:*

I hereby authorize my insurance company to pay the proceeds of any benefits due directly to Dr. Donald G. Nield. I hereby agree to pay copayment portions/ deductibles at the time services are provided. I also acknowledge that any remaining balances, after payment of my copayment insurance benefits, due and payable to Dr. Donald G. Nield, are my responsibility.

Sign: ______________________________

____
Date:

AUTHORIZATION / RESPONSIBILITY AGREEMENT

* *This portion to be filled out by patients who do not currently have dental insurance coverage:*

I hereby agree to pay my account when services are provided. If for any reason there is a balance owing on my account, I agree to promptly pay that balance upon receipt of the monthly statement. I understand that failure to pay my balance in a timely manner will result in late fees of 15.00 dollars a month, until my account is paid in full.

Sign: ______________________________

____
Date:

BY SIGNING THIS DOCUMENT I ALSO ACKNOWLEDGE THAT ALL X-RAYS, MODELS, & MATERIALS ARE THE PROPERTY OF THE OFFICE OF DR. DONALD G. NIELD.

DONALD G. NIELD, D.M.D., P.C.

NOTICE OF PRIVACY PRACTICES

Acknowledgment of Receipt

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

____

Please Print Name

____

Signature

____

Date of Signature

* You may refuse to sign this acknowledgment *

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our **Notice of Privacy Practices** and acknowledgment could not be obtained because:

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