PATIENT REGISTRATION

DATE: _____

ADULT PATIENT

Name _____

Address_____

City_____ State_____ Zip_____

Email_____

Landline_____

Cell Phone_____

Do you work? _____ Where?_____

Work Phone_____

Date of Birth_____

Social Security #_____

Single ___ Married ___ Divorced ___ Widowed___

CHILD PATIENT

Name of child_____

Date of birth_____

Address_____

City _____State_____Zip_____

Email_____

Landline_____

Cell Phone_____

Name of School_____

Last visit to the dentist_____

Mother's Name_____

Father's Name_____

PERSON RESPONSIBLE FOR PAYMENT OF THE DENTAL BILL

Name_____

Address_____

City, State, Zip _____

Landline_____

Cell Phone_____

Email _____

Physician's Name_____

Pharmacy Name_____

Employer_____

Work Phone_____

Social Security Number _____

Drivers License Number _____

Date of Birth_____

Relationship to Patient_____

Physician's Phone Number_____

Pharmacy Phone Number_____

How do you prefer to be reminded of your dental appointments?

Text Message _____ Email _____ Phone Call _____ All 3 _____

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

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

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____

Are you on a special diet? ◯ Yes ◯ No

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Women: Are you

☐ Pregnant/Trying to get pregnant? ☐ Nursing?

☐ Taking oral contraceptives?

Are you allergic to any of the following?

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

☐ Other If yes, please explain: _____

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

☐ AIDS/HIV Positive	☐ Chest Pains	☐ Frequent Headaches	☐ Hypoglycemia	☐ Rheumatic Fever
☐ Alzheimer's Disease	☐ Cold Sores/Fever Blisters	☐ Genital Herpes	☐ Irregular Heartbeat	☐ Rheumatism
☐ Anaphylaxis	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Kidney Problems	☐ Scarlet Fever
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Leukemia	☐ Shingles
☐ Angina	☐ Cortisone Medicine	☐ Heart Attack/Failure	☐ Liver Disease	☐ Sickle Cell Disease
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur	☐ Low Blood Pressure	☐ Sinus Trouble
☐ Artificial Heart Valve	☐ Drug Addiction	☐ Heart Pacemaker	☐ Lung Disease	☐ Spina Bifida
☐ Artificial Joint	☐ Easily Winded	☐ Heart Trouble/Disease	☐ Mitral Valve Prolapse	☐ Stomach/Intestinal Disease
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Osteoporosis	☐ Stroke
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Pain in Jaw Joints	☐ Swelling of Limbs
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Breathing Problem	☐ Excessive Thirst	☐ Herpes	☐ Psychiatric Care	☐ Tonsilitis
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ High Blood Pressure	☐ Radiation Treatments	☐ Tuberculosis
☐ Cancer	☐ Frequent Cough	☐ High Cholesterol	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hives or Rash	☐ Renal Dialysis	☐ Ulcers
				☐ Venereal Disease
				☐ Yellow Jaundice

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: _____

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.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

PRIMARY DENTAL INSURANCE

Name of insured_____

Phone Number_____

SSN_____

Date of Birth_____

Mailing Address_____

_____

Employer_____

Name of Insurance Company_____

Phone Number_____

SECONDARY DENTAL INSURANCE

Name of insured_____

Phone Number_____

SSN_____

Date of Birth_____

Mailing Address_____

_____

Employer_____

Name of Insurance Company_____

Phone Number_____

MEDICAL – DENTAL INSURANCE AUTHORIZAION SIGNATURE ON FILE

- I understand that I am responsible for payment of my bill in full.
- I authorize use of this form on all my insurance submissions.
- I authorize release of information to all my insurance carriers.
- I authorize Dr. Hendrix or his staff to act as my agent in helping me obtain payment from my insurance carrier.
- I authorize payment directly to Dr. Hendrix.
- I permit a copy of this authorization to be used in place of the original.

PATIENT NAME _____

INSURED'S NAME_____

SIGNATURE OF INSURED_____ DATE_____

Prescription Drug Policy

Prescriptions will not be refilled after normal business hours, on holidays or weekends when the doctor does not have your records. This is for your safety and the safety of others. An early refill on your pain medicine will NOT be granted if you take more than the prescribed amount.

Prescriptions will not be refilled if you have cancelled your last appointment, did not show for your last appointment, if you do not follow through with recommended treatment/testing, you have been discharged from the practice, or if you were to return only as needed.

WE DO NOT PRACTICE PAIN MANAGEMENT.

Prescriptions that have been lost (or discarded) will not be refilled.

Prescriptions that have been stolen will not be refilled.

During the time of your care in this office, unless we have referred you to a pain management specialist, this office will be the ONLY SOURCE OF YOUR PAIN MEDICINE. You may still receive other medication (for example, antibiotics) from your family doctor, but only ONE doctor at a time should be prescribing your pain medication.

It is our **LEGAL DUTY** to report to the authorities the name of a patient whom we believe may be taking, selling, or distributing narcotics or other medications illegally.

We reserve the right to terminate the doctor-patient relationship in the event of any breech in this policy by the patient.

I HAVE READ THE ABOVE AND UNDERSTAND THE PRESCRIPTION POLICIES.

Patient Signature_____ Date _____

We like to give thanks to those who refer friends and family to our office.
Please circle how you first heard of us.

Family Friend Coworker Doctor Pharmacist

Please give us the name of the person who referred you. _____

Internet: Google.com Yelp.com Yahoo.com Local.com

CitySearch.com Superpages.com YellowBot.com WhitePages.com

Yellowbook.com Mapquest.com FaceBook Twitter

GooglePlaces.com Other internet site _____

Outside Signs Coupon TV Radio Other Ad

Newspaper Yellow Book Yellow Pages

Thank you for choosing **Glenn M. Hendrix, DDS**, as your dental health care provider. Dr. Hendrix and his dental team are committed to the success of your dental treatment by providing you with the highest quality care available. In order to help reduce our administrative costs and to keep our fees to you as low as possible, we require payments to be made at the time you receive treatment, or before.

We are pleased to offer our patients the following payment options:

- Cash *****
- Check *****
- Major Credit Card (Visa, MasterCard, AMEX, and Discover) *****
- Interest-Free Payment Plan (with approved credit)
- Extended payment plan (with approved credit)
- Lay-Away Plan

*****A courtesy fee reduction may apply

A note to our patients with dental insurance:

As a courtesy to our patients, we will process your insurance claim; however, dental insurance rarely covers the total cost of treatment. Your co-insurance, the **estimated** amount not covered by dental insurance, is due at or prior to the time of treatment. You will be responsible, in total, for remaining account balances after 30 days.

Appointment Cancellations and Missed Appointments hurt you and your oral health. Others who are in pain and in need of seeing Dr. Hendrix are also hurt. We request a minimum of 48 hours notice for any cancellation in order to assist others in need. Should an appointment be missed, there will be a charge imposed commensurate with the length of the scheduled appointment.

Acceptance of Financial Agreement:

I understand, and accept, the above financial terms. I further understand that I am ultimately responsible for the payment of ALL fees incurred by myself or on behalf of any minor children I may bring into this office for treatment, regardless of insurance coverage. I understand that payment for all dental services is due in full, within 30 days from the date-of-service, regardless of whether or not my insurance payment has been received. I also understand and agree that I will be responsible for all collection costs, including court costs and attorney fees, in addition to the balance owed should my account be sent to a collection agency.

Signature of Patient/Parent/Guardian Date

PLEASE READ CAREFULLY
AGREEMENT AS TO RESOLUTION OF CONCERNS

"I", "Patient/Guardian" shall be understood to mean _____.
(Patient Name)

"Doctor" shall be understood to mean Glenn M. Hendrix, DDS/Glenn M. Hendrix, DDS, PLLC.

I understand that I am entering into a contractual relationship with Doctor for professional care. I further understand that meritless and frivolous claims for medical/dental malpractice have an adverse effect upon the cost and availability of care to patients and may result in irreparable harm to a healthcare provider. As additional consideration for professional care provided to me by the doctor, I, the Patient/Guardian, agree not to initiate or advance, directly or indirectly, any meritless or frivolous claims of medical/dental malpractice against the Doctor.

Should I initiate or pursue a meritorious medical/dental malpractice claim against Doctor, I agree to use as expert witnesses (with respect to issues concerning the standard of care), only doctors who practice primarily in the same specialty as the Doctor. Further, I agree that these doctors retained by me or on my behalf to be expert witnesses will be members in good standing of the Academy of General Dentistry.

I agree the expert(s) will be obligated to adhere to the guidelines or code of conduct defined by the Academy of General Dentistry and that the expert(s) will be obligated to fully consent to formal review of conduct by such society and its members.

I agree to require any attorney I hire and any doctor hired by me or on my behalf as an expert witness to agree to these provisions.

In further consideration, Doctor also agrees to exactly the same above-referenced stipulations.

Each party agrees that a conclusion by a specialty society affording due process to an expert will be treated as supporting or refuting evidence of a frivolous or meritless claim.

Patient/guardian and doctor agree that this Agreement is binding upon them individually and their respective successors, assigns, representatives, personal representatives, spouses and other dependents.

Doctor and patient/guardian agree that these provisions apply to any claim for medical/dental malpractice whether based on a theory of contract, negligence, battery or any other theory of recovery.

Patient/guardian acknowledges that he/she has been given ample opportunity to read this agreement and to ask questions about it.

_____	_____
Glenn M. Hendrix, DDS	Signed: Patient/Guardian
_____	_____
Effective from Date of Treatment:	Date of Signature

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state 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 must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. 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 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. **USES AND DISCLOSURES OF HEALTH INFORMATION**. We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

We may use or disclose your health information to a physician or other healthcare provider providing treatment to you. We may use and disclose your health information to obtain payment for services we provide to you.

We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. In addition to our use of your health information for treatment, payment or healthcare 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 an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

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 healthcare or with payment for your healthcare, but only if you agree that we may do so. 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, of 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 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 healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

We will not use your health information for marketing communications without your written authorization. We may use or disclose your health information when we are required to do so by law. We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the 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. 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 institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).Patient Rights Access: You have the right obtain your health information with limited exceptions. 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. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. Fees for providing this information are $0.50 for each page, $25.00 per hour for staff time to locate and transcribe your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

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, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. 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). 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 satisfactory explanation how payments will be handled under the alternative means or location you request. You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances. 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.

If you want more information 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 complain to us using the contact information listed at the end of this Notice. 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. We 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.

Contact this office if you have any questions or complaints: Glenn M. Hendrix, DDS, PLLC email: hendrixdds@gmail.com

2113 Government Street Suite K-1, Ocean Springs, MS 39564 Phone 228/826-3811 Fax 228/826-3813

Glenn Hendrix, DDS, PLLC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

I, _____, have read a copy of this office's Notice of Privacy Practices.

{Print Name of Patient}

I, hereby, authorize the dentist and staff of this office to give information concerning my dental health and necessary treatment to the following persons, as needed:

Full Name	Relationship
_____	_____
_____	_____
_____	_____

I understand that I may revoke this consent at any time by given written notice to this office.

Signed Patient, Parent or Guardian:_____

Date:_____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement 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)

_____