Prisma dental
(972) 668-7398

PATIENT REGISTRATION

PLEASE WRITE CLEARLY

Name:_________________________________ **Last Name**:_________________________________ **Middle Initial**:_______

The Patient is: ◯ The insurance holder ◯ Responsible party ◯ Dependant of the insured Preferred Name:________________

PATIENT INFORMATION

Address:____ **Apt#**__________ **City**:_________________ **State**:_____

Zip:_________________ **Phone Home**: __________________________ **Cell**: ________________________

Work Phone:_____________________ Marital Status: _____Married _____Single _____Widowed _____Separated _____Divorced

Date of Birth:_______________________ **Social Security Number** :___________________________

E-Mail:____ **Gender**:◯ Male. ◯ Female.

RESPONSIBLE PARTY (if other than patient)

Name:__________________________________ **Last Name**:______________________________ **M.I.**:__________

Address____ **City**:_________________ **State**:_____ **Zip**:________________

Phone Home:________________________ Work :________________________ Cell________________________

Social Security Number:_____________________________ Gender: _____ Male _____Female

Date of Birth:________________________ **E-Mail**:____

INSURANCE INFORMATION (INSURANCE HOLDER)

Name:__________________________________ **Last Name**:______________________________ **M.I**:________

Address:____ City/State/Zip:__________________________________

Social Security # (Insurance Holder): _____________________________ **Date of Birth (Insurance Holder)**: ____________________

Name of Insurance Company :________________________ **Member Ins.ID#** ___________________________________

Name of Company (where Insurance Holder Works): ______________________________ **Ins Co. Phone #**________________________

Ins. Co. Address: ____ **Work Phone #** ________________________

City/State/Zip__________________________________ **Home Phone #** :_________________________**Cell #** ____________________

WE AT PRISMA DENTAL PLLC SEND A BILL TO YOUR INSURANCE COMPANY AS A COURTESY TO YOU, OUR PATIENT; HOWEVER, ULTIMATELY, THE PATIENT (OR PARENT(S) /GUARDIAN(S) IS/ARE RESPONSIBLE FOR ALL CHARGES FROM ALL SERVICES PROVIDED.
AFTER THE INSURANCE COMPANY PAYMENT, ANY BALANCES, CO-PAYS, CO-INSURANCES AND ANY DIFFERENCE BETWEEN THE CHARGES SUBMITTED AND WHAT YOUR INSURANCE COMPANY PAYS IS YOUR RESPONSIBILITY. SUBMISSION OF INSURANCE CLAIMS DOES NOT GUARANTEE PAYMENT. IT IS IN YOUR BEST INTEREST TO UNDERSTAND YOUR INSURANCE POLICY AND COVERAGE.

I HEREBY CERTIFY THAT I HAVE READ THESE TERMS AND AGREE TO THEM. I UNDERSTAND THAT ANY BALANCE(S) REMAINING (OR DIFFERENCE BETWEEN THE TOTAL AMOUNT CHARGED AND WHAT THE INSURANCE COMPANY PAYS) IS MY RESPONSIBILITY. I ACCEPT THE TERMS OF THIS CONTRACT AND ALL POLICIES FROM PRISMA DENTAL AND AGREE TO THEM. I AUTHORIZE PRISMA DENTAL PLLC TO USE MY PERSONAL AND MEDICAL(OR THE PATIENT'S) INFORMATION FOR THE PURPOSE OF GETTING PAYMENT FOR THE DENTAL SERVICES I HAVE BEEN PROVIDED. I AUTHORIZE PRISMA DENTAL TO ADD $38.oo TO MY BILL IF A COLLECCION AGENCY NEEDS TO BE USED TO COLLECT ANY DUE BALANCE(S). IF SUCH COLLECTION ENDS UP BEING MOVED TO PHASE 2 -difficult to collect accounts-, I AUTHORIZE PRISMA DENTAL, PLLC TO CHARGE UP TO 50% OVER THE AMOUNT OWED TO COVER THE ADDITIONAL COLLECTION COSTS.

PATIENT / GUARDIAN / PARENT'S SIGNATURE: ____

Date: _______________________ **Print Your name here if you are not the Patient**:____________________________________

DATE: ____________________

FINANCIAL POLICY

INSURANCE:

We will bill your insurance company as a courtesy to you; however, this does **NOT** guarantee payment. Ultimately, all charges are the responsibility of the patient/responsible party when insurance company does not provide payment for any reason. Any balance(s) left after the insurance Payment becomes the responsibility of the Patient's/Responsible Party. Co-pays, deductibles, co-insurance charges, etc are the responsibility of the patient. Please keep in mind that the cost of your treatment is dictated by your insurance company and the amount we tell you they may pay is **ONLY an estimate**. It is in your best interest to understand your insurance policy plan and coverage.

PAYMENTS:

Payment is expected at the time of service unless prior arrangements have been made. We accept cash, Visa, MasterCard, Discover, Amex, Springstone Credit and CareCredit**.** We also offer PRISMA DENTAL'S own financial plan. We call it the "*Pay as you go*" plan which consists of payments as the treatment progresses. There are no financial charges and patient will only pay when he/she comes for an appointment. Please ask us for details as ***there are exceptions*** on some procedures . When our discount plan is purchased and used we **do not** accept payments with Springstone plan or CareCredit. In addition, please keep in mind that we use a Collection Agency for bills over 30 days past due. When a bill is sent to the collection agency, the patient/Responsible party agrees to pay a $38.oo collection fee charge. This fee is NOT negotiable and becomes the responsibility of the patient/responsible party on the account. I authorize PRISMA DENTAL to add $38.oo to my bill if a collection agency needs to be used to collect any due balance(s). If such collection ends up being moved to phase 2 - difficult to collect accounts - I authorize Prisma Dental,PLLC to charge up to 50% over the amount owed to cover the additional collection costs. Make sure you agree to these collection charges before signing this contract.

SORRY, WE DO NOT TAKE PERSONAL CHECKS. PLEASE KEEP THIS IN MIND.

FINANCIAL CHOICES:

We offer Lending Club Patient Solutions, CareCredit, Prosper Lending, and our own Prisma Dental financial plan. Please consider all these options. We'll be happy to discuss any questions you may have.

APPOINTMENTS:

Appointments are reserved exclusively for each patient. We ask patients to please notify at least 24hrs prior to their scheduled time if the appointment cannot be kept. Failure to notify us on time will result in a $30.oo charge for the first and $40.oo for the second missed appointment. Three or more non notified appointments may result in dismissal from the practice.

By signing this form **I AGREE** and accept these terms and conditions

PATIENT NAME:_______________________________________ SIGNATURE:_________________________________

This document is NOT to be signed by a minor

SIGNER (PRINT NAME):_________________________________ Relation To Patient:_________________________

Print name ONLY if you are not the patient

PRIVACY POLICY ACKNOWLEDGEMENT

We are very concerned about the protection of your privacy, especially in matters that concern your personal health information. In accordance with the Health Insurance Portability and Accountability Act of 1196 (HIPPA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully for it outlines the use limitations of the disclosure of your health information and your rights as a Patient. If you ever have any questions or concerns regarding the use of dissemination of your personal health information, we would be happy to answer or discuss the matter with you.

I acknowledge that I have been offered a copy of PRISMA DENTAL'S privacy practices for protected information. I may decline the receipt of such documents at my own discretion.

Patient Name: ___________________________________ Date: _____________________

Patient/Parent(s)/Guardian Signature: ____

This document is NOT to be signed by a minor

Please **print your name** if signer is NOT the Patient:____________________________________

Relation to Patient: ___________________________________

MEDICAL HISTORY

PATIENT'S NAME:____ **DATE:**________________

Although dental personnel primarily treat the area in and around the mouth, your mouth is a part of your entire body. Health problems that you may have or have had in the past, as well as medications you are taking, could have an important interrelationship with the dentistry you will receive.

PLEASE BE AS ACCURATE AS POSSIBLE WITH THE INFORMATION YOU ARE PROVIDING TO US. Thank you for answering these questions.

Are you under a Physician's care at the present?	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 of any kind?	Yes__	No___	If yes, please explain:________________________________
Do you take, or have you taken, Phen-Fen or Redux?	Yes__	No___	If yes, please explain:________________________________
Are you on a special Diet?	Yes__	No___	If yes, please explain:________________________________
Do you smoke or use Tobacco?	Yes__	No___	If yes, please explain:________________________________
Do you use Controlled or ANY Illegal Substances?	Yes__	No___	If yes, please explain:________________________________

WOMEN

Are you: Pregnant/trying to get pregnant? Yes___ No___ Taking Oral Contraceptives? Yes___ No___ Nursing? Yes___ No___

DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING ***PLEASE CIRCLE YOUR ANSWER OR MARK AN "X"***

AIDS / HIV	Yes___	No___	Cortisone Medicine	Yes___	No___	Hemophilia	Yes___	No___	Renal Dialysis	Yes___	No___
Alzhaimer's desease	Yes___	No___	Diabetes	Yes___	No___	Hepatitis A	Yes___	No___	Rheumatic Fever	Yes___	No___
Anaphylaxis	Yes___	No___	Drug Addiction	Yes___	No___	Hepatitis B or C	Yes___	No___	Rheumatism	Yes___	No___
Anemia	Yes___	No___	Easily Winded	Yes___	No___	Herpes	Yes___	No___	Scarlet fever	Yes___	No___
Angina	Yes___	No___	Emphysema	Yes___	No___	High Blood Pressure	Yes___	No___	Shingles	Yes___	No___
Arthritis / Gout	Yes___	No___	Epilepsy / Seizures	Yes___	No___	Hives or Rash	Yes___	No___	Sickle cell desease	Yes___	No___
Artificial Heart Valve	Yes___	No___	Excessive bleeding	Yes___	No___	Hypoglycemia	Yes___	No___	Sinus trouble	Yes___	No___
Artificial Joint	Yes___	No___	Excessive thirst	Yes___	No___	Irregular Heartbeat	Yes___	No___	Spina bifida	Yes___	No___
Asthma	Yes___	No___	Fainting spells/Dizziness	Yes___	No___	Kidney problems	Yes___	No___	Stomach desease	Yes___	No___
Blood disease	Yes___	No___	Frequent cough	Yes___	No___	Leukemia	Yes___	No___	Intestinal desease	Yes___	No___
Blood transfusion	Yes___	No___	Frequent diarrhea	Yes___	No___	Liver desease	Yes___	No___	Stroke	Yes___	No___
Breathing problem	Yes___	No___	Frequent headaches	Yes___	No___	Low Blood pressure	Yes___	No___	Swelling of limb	Yes___	No___
Bruise easily	Yes___	No___	Genital herpes	Yes___	No___	Lung desease	Yes___	No___	Thyroid desease	Yes___	No___
Cancer	Yes___	No___	Glaucoma	Yes___	No___	Mitral Valve prolapse	Yes___	No___	Tonsilitis	Yes___	No___
Chemotherapy	Yes___	No___	Hay Fever	Yes___	No___	Pain in Jaw Joints	Yes___	No___	Tuberculosis	Yes___	No___
Chest pains	Yes___	No___	Heart Attack / Failure	Yes___	No___	Parathyroid desease	Yes___	No___	Tumors or Growths	Yes___	No___
Cold sores/Fever blisters	Yes___	No___	Heart Murmur	Yes___	No___	Psychiatric care	Yes___	No___	Ulcers	Yes___	No___
Congenital Heart Disorder	Yes___	No___	Heart Pace Maker	Yes___	No___	Radiation treatments	Yes___	No___	Venereal desease	Yes___	No___
Convulsions	Yes___	No___	Heart Trouble/Desease	Yes___	No___	Recent weight loss	Yes___	No___	Yellow jaundice	Yes___	No___

Have you ever had ANY serious illnesses not mentioned above? Yes___ No___ If Yes, Please explain:

USE THIS SPACE TO WRITE EXPLANATIONS OR COMMENTS:____

____

ALLERGIES: Are you allergic to: Asprin______ Codeine______ Penicillin______ Latex_______ Acrylic______ M

Metal_____ Anesthetics_______ Other______ Please Specify Allergy_____________

____

The questions on this form have been accurately answered to the best of my knowledge. I understand that providing incorrect information can be **DANGEROUS** to my/Patient's health. It is my responsibility to inform Prisma Dental, at every visit, of any changes in my/Patient's medical condition.

SIGNATURE OF PATIENT, GUARDIAN OR PARENTS:____

Please Print name of Signer:______________________________ Relation to Patient___________________

EMERGENCY CONTACTS

If Medical and/or Dental urgent care is needed and, for any reason the parent(s)/Guardian(s) are not present, we will require a list of people that may be contacted if need be. Please list at least 3 people we may contact in an emergency:

First Name_____________________ Last Name_____________________ Phone#_______________________ Relation to Patient__________________

First Name_____________________ Last Name_____________________ Phone#_______________________ Relation to Patient__________________

First Name_____________________ Last Name_____________________ Phone#_______________________ Relation to Patient__________________

First Name_____________________ Last Name_____________________ Phone#_______________________ Relation to Patient__________________

First Name_____________________ Last Name_____________________ Phone#_______________________ Relation to Patient__________________

In case of an emergency situation and I am not present, I, Parent/Guardian of ______________________________ authorize any of these people mentioned above to make decisions for treatment for the patient named above, even if they are life threatening.

Parent/Guardian name:_____________________________________ Signature:____________________________________

Print name

Today's Date: Day________ Month_________________ Year _________.

WHO REFERED YOU TO US OR HOW DID YOU FIND US: **Internet - Bulletin - Magazine - Referred by**_____________________________________

Please circle one **NAME OF PERSON OR INS. COMPANY**