Dr. Anu Amara
14725 Lebanon Road, Suite 200, Frisco, Texas 75035
469-250-2020

PATIENT REGISTRATION

PATIENT INFORMATION

NAME ____ DATE _________________________
FIRST MI LAST

ADDRESS ________________________________CITY _______________STATE__________ZIP ____________
E-MAIL __________________CELL PHONE ____________________ HOME PHONE ____________________

SSN_____________________ BIRTHDATE _____________________ GENDER ☐ Male ☐ Female

CHECK APPROPRIATE BOX: ☐MINOR ☐SINGLE ☐MARRIED ☐DIVORCED ☐WIDOWED ☐SEPARATED
PATIENT'S OR PARENT'S/GUARDIAN'S EMPLOYER______________________WORK PHONE_____________
BUSINESS ADDRESS ___________________________CITY ____________STATE___________ZIP___ _______
SPOUSE OR PARENT'S/GUARDIAN'S NAME___________________________ _WORK PHONE_____________
WHOM MAY WE THANK FOR REFERRING YOU? ____
PERSON TO CONTACT IN CASE OF AN EMERGENCY _____________________ PHONE __________________

RESPONSBILE PARTY

NAME OF THE PERSON RESPONSIBLE FOR ACCOUNT______________________RELATIONSHIP TO PATIENT_____________
ADDRESS ____ HOME PHONE_____________________
DRIVER'S LICENSE # _______________ BIRTHDATE ________________ SSN ___________________________
EMPLOYER ____WORK PHONE___________________

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

INSURANCE INFORMATION

NAME OF INSURED____RELATIONSHIP TO PATIENT_____________
INSURANCE CO. _______________________________TEL. #________________GRP #___________________
INS. CO. ADDRESS _____________________________CITY ___________STATE_____ZIP _________________
BIRTH DATE ____________________ SSN ____________ID #________DATE EMPLOYED________________
NAME OF EMPLOYER__________________ UNION OR LOCAL # __________ WORK PHONE______________
EMPLOYER ADDRESS _________________________CITY ____________STATE_____ZIP ________________

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED____RELATIONSHIP TO PATIENT_____________
INSURANCE CO. _______________________________TEL. #________________GRP #___________________
INS. CO. ADDRESS _____________________________CITY ___________STATE_____ZIP _________
BIRTH DATE ____________________ SSN ____________ID #________DATE EMPLOYED______________
NAME OF EMPLOYER__________________ UNION OR LOCAL # __________ WORK PHONE______________
EMPLOYER ADDRESS _________________________CITY ____________STATE_____ZIP ________________

____ ________________________
SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR DATE

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MEDICAL HISTORY

Your physician:____ Date of last visit: ___________

Have you ever taken any of the groups of drugs collectively referred to as "fen-phen"? ☐ YES ☐ NO

Have you had any serious illnesses or operations? ☐ YES ☐ NO
If yes, describe: ____

Have you ever had a blood transfusion? ☐ YES ☐ NO
If yes, give approximate dates: ____

Have you ever taken Bisphosphonates e.g. Boniva, Fosamax? ☐ YES ☐ NO

Do you use any form of tobacco? ☐ YES ☐ NO

Women: are you pregnant? ☐ YES ☐ NO

Are you nursing? ☐ YES ☐ NO

Are you taking birth control? ☐ YES ☐ NO

Check if you have or have had any of the following:

- ☐ Anemia
- ☐ Arthritis, rheumatism
- ☐ Artificial heart valves
- ☐ Artificial joints, pins, etc.
- ☐ Asthma
- ☐ Bacterial endocarditis
- ☐ Bleeding abnormally
- ☐ Blood pressure
- ☐ Blood disease
- ☐ Cancer
- ☐ Chemical dependency
- ☐ Chemotherapy
- ☐ Circulatory problems
- ☐ Congenital heart disease
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Emphysema
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart murmur
- ☐ Heart problems
- ☐ Hemophilia
- ☐ Hepatitis-Type __
- ☐ HIV+/AIDS
- ☐ HPV
- ☐ Jaw pain
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Mitral valve prolapse
- ☐ Pacemaker
- ☐ Psychiatric care
- ☐ Radiation treatment
- ☐ Respiratory disease
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Sexually transmitted disease
- ☐ Shortness of breath
- ☐ Sinus trouble
- ☐ Stroke
- ☐ Swelling of feet or ankles
- ☐ Thyroid problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Weight/Loss

List medications you are currently taking and the correlating diagnosis:

Medications / Herbal supplements	Diagnosis

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Check substances that cause you to have allergic or unfavorable reactions:

- ☐ Aspirin
- ☐ Barbiturates
- ☐ Codeine
- ☐ Dental anesthetics
- ☐ Iodine
- ☐ Latex
- ☐ Metals
- ☐ None
- ☐ Other__________
- ☐ Penicillin
- ☐ Sedative
- ☐ Sulfa drugs

____ ____________________
SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR DATE

____
Provider's Signature

Dental History:

Reason for today's visit ____
Date of last dental care visit_____________________ Date of last dental x-rays_ _____________________
Former dentist's name ____ Phone__________________
Is there anything you would like to change about your smile? ________________________________
Do you have any dental concerns? ____
Are you currently in pain? ____
Are you happy with the color of your teeth? _______________________________________
Are you happy with your smile? ____
Do you now, or have you ever experienced pain/ discomfort in your jaw joint? (TMD/TMJ) ______________
How do you rate your overall dental health: Excellent____Good____Fair____Poor____?

Check if you have any problems with the following:

- ☐ Bad breadth
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between certain teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to any of the following: cold, hot, sweets
- ☐ Sensitivity when biting
- ☐ Sores or growth in your mouth

How often do you floss? _____________________ How often do you brush? _______________________

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HIPAA FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment form third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to tome and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: ____

Signature: ____

Relationship to Patient: ____

Date: ____

I allow for release of my x-rays and records to my insurance company as needed for proper processing and payment of my dental claims. I allow for release of my x-rays and records to other dental and medical specialists, as needed, for my dental care. I also allow for photographs to be taken of my mouth and dental work as a record of progress of my treatment.

Patient Signature: ___________________________ DATE: _____________________________

Our office is HIPPA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, The CDC and the ADA.

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OUR FINANCIAL POLICY

Thank you for choosing our practice as your healthcare provider. Our office is dedicated to providing optimal care for every patient in the most economical way possible. The following is a statement of our financial policy. Please read it and let us know if you have any questions.

OPTIONS FOR PAYMENT OF TREATMENT:

1. Non-Insurance Patients:
   Payment is expected at the time of service for treatment performed that day unless prior arrangements have been made. For your convenience, we accept cash,
   American Express, MasterCard, Visa or Visa check cards, Care Credit.

2. Insurance Policy:
   a. We will file an insurance claim on your behalf as a courtesy to you; however, you must supply, prior to treatment, all the necessary information for filing.
   b. Any deductible as well as any estimated percentages your insurance does not cover, are to be paid on the date of the treatment.
   c. It is the patient's responsibility to know the details of the insurance coverage, including percentages payable, waiting periods, deductibles, yearly maximums, services not covered under the plan, and any other related information.
   d. If your insurance company has not paid their liability in full within 30 days, the balance then becomes the patient's liability.
   e. For patients whose insurance company pays them directly, payment is expected on the date of the treatment.
   f. Your insurance policy is a contract between you and your insurance company and the financial responsibility for your treatment is yours whether the insurance company pays or not.

I understand that NYSA Family Dental has a 24-HOUR cancellation policy. If an appointment is changed or cancelled without 24 hours' notice there will be a fee incurred.

Again, please feel free to ask any questions that you may have regarding this policy. We are most willing to help you in any way that we can.

I HAVE READ THIS FINANCIAL POLICY AND UNDERSTAND AND AGREE TO THE TERMS OF THIS POLICY.
X____ DATE: ______________________________
Signature of Patient/Responsible Party

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NYSA DENTAL

General Consent for Treatment

This form is intended to help you make an informed decision about your dental treatment.
To increase the chance of achieving optimal results, you have provided and accurate and complete medical history, including all past and present dental and medical conditions, prescription and nonprescription medications, any allergies, recreational drug use and pregnancy (if applicable). Dr Amara will be happy to answer any questions you may have before signing this document.

Consent:
I consent to the diagnostic procedures including x-rays and any other diagnostic procedures needed to diagnose correctly and treatment necessary by the dentist necessary for proper dental care. I consent to the dentist's use and disclosure of my records (or my child's record) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.

Anesthesia:
I have been told that there may anesthesia administered when I receive dental care. I fully understand the risks associated with the use of anesthetic. I hereby give my free and voluntary informed consent for the use of anesthesia.

I have been informed and understand that some possible complications but not limited to include:

- Pain, infection, swelling, bleeding, bruising, discoloration, cracking and bruising of the lops and corners of the mouth.
- Temporary or permanent numbness and tingling of the lip, chin, tongue, gums, cheek or teeth.
- Nausea, vomiting, allergic reaction.
- Change in occlusion, temporal-mandibular joint difficulty, trismus.
- Numbness or inflammation from the injection, and unfavorable reactions to drugs and anesthetics.

Signature: ______________________________________ Date: ____________________