NTFOS

Welcome! *Thank you* for completing this registration form.

Patient Information

Full Name:	Nickname:	Birth Date:	Age:	Sex: *M F*
Address:	City		State	Zip
E-mail address:	Primary Daytime Phone	Other Phone		
Employer/School:	Employer Phone	Status: *Full Time Part Time Retired*		
Employer Address:	Employer City	State	Zip	
Occupation	DL#:	Marital Status: *S M D W*		
Emergency Contact *(not in same household)*:	Relationship:	Phone:		

Visit Info

Reason for visit	Accident Related? *Work Auto Other*	Date of Injury
If your visit is for an implant: ❑ *Tooth is in place* ❑ *Tooth was removed/lost on* _____ *(approximate date)*		
Referred by:	Family or Friend who has seen us	Pharmacy Phone #
Dentist:	Primary Care Physician Name and Phone:	Orthodontist (if applicable)

For Minor Children

Person Accompanying Patient to Visit:	Birth Date:	Relationship to Patient: *Parent Other*	
Address (if different from patient)	City:	State	Zip
E-mail address:	Primary Daytime Phone	Other Phone	
Occupation	DL#		
Employer/School:	Employer Phone	Status: *Full Time Part Time Retired*	
Employer's Address:	Employer City:	State	Zip

Dental Insurance
(Please provide card for copying.)

Insurance Company Name	
Insurance Company Phone	
Policy Holder's First Name	Last Name
Date of Birth	Relationship to Patient *Parent Spouse Other*
Street Address	
City, State, Zip	
SS/ Policy Number	
Group Number	
Employer	

Medical Insurance
(Please provide card for copying)

Insurance Company Name	
Insurance Company Phone	
Policy Holder's First Name	Last Name
Date of Birth	Relationship to Patient *Parent Spouse Other*
Street Address	
City, State, Zip	
SS/ Policy Number	
Group Number	
Employer	

Northern Texas Facial and Oral Surgery *Confidential* Patient History

Name:	DOB	Age	Sex

Are you in good health? ❑Yes ❑No	Date of last physical exam:	Height	Weight

Has there been any change in your general health in the past year? If yes, please describe.

Are you now under a physician's care for a particular problem? If yes, what?

Have you ever had any serious illnesses, operations, or hospitalizations? If yes, please describe.

Do you have or have you ever had any disease, drugs, transplant operations that depressed your immune system? (Specify)

1. Do you have or have you ever had:

Rheumatic fever or rheumatic heart disease	❑Y	❑N
Congenital heart disease	❑Y	❑N
Cardiovascular disease (high blood pressure, heart trouble/attack, murmur, angina, stroke, coronary artery disease, palpitations, surgery, pacemaker, etc.)	❑Y	❑N
Lung disease (asthma, emphysema, chronic cough, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing, etc.)	❑Y	❑N
Neurological or psychological disorders (convulsions, epilepsy, seizures, fainting, psychiatric treatment, dizziness, nervous disorder, breakdown, etc.)	❑Y	❑N
Blood disease (anemia, bruise easily)	❑Y	❑N
Liver disease	❑Y	❑N
Kidney disease	❑Y	❑N
Diabetes	❑Y	❑N
Thyroid disease (goiter)	❑Y	❑N
Arthritis	❑Y	❑N
Stomach ulcers or colitis	❑Y	❑N
Glaucoma	❑Y	❑N
Frequent or recurring mouth sores	❑Y	❑N
Radiation for cancer	❑Y	❑N
Cancer treatment, chemotherapy, etc.	❑Y	❑N
Sinus or nasal problems	❑Y	❑N
Recurrent infections of any kind	❑Y	❑N
AIDS or HIV+	❑Y	❑N

2. If applicable, list all implants you have (heart valve, hip, knee, etc.)

3. Are you allergic to or have you had a bad reaction to:

Local anesthetic (Novocaine, etc.)	❑Y	❑N
Antibiotics (specify under #4 below)	❑Y	❑N
Sedatives or general anesthesia.	❑Y	❑N
Aspirin	❑Y	❑N
Codeine or other pain killers	❑Y	❑N
Latex	❑Y	❑N

4. Other allergies or reactions? (Specify)

5. Are you using or taking any of the following at any time, whether occasionally or regularly?

Cancer treatment, chemotherapy, etc.	❑Y	❑N
Anticoagulants (blood thinners)	❑Y	❑N
High blood pressure medicine	❑Y	❑N
Steroids	❑Y	❑N
Tranquilizers	❑Y	❑N
Insulin, oral therapy	❑Y	❑N
Digitalis, Inderal, Nitroglycerin or other heart medicine	❑Y	❑N
Aspirin? How much daily?	❑Y	❑N
Marijuana or other "street drugs"	❑Y	❑N
Women: birth control pills	❑Y	❑N
Inhalers		

Please list all medications, including prescription, over the counter, vitamin and herbal supplements.)

6. Women: Are you pregnant or planning pregnancy? ❑Y ❑N
7. Do you have any other disease, condition, or problem not listed? (Specify) ❑Y ❑N
8. Do you snore? ❑Y ❑N
9. Do you use tobacco? If so, what type? _____ ❑Y ❑N
10. Do you drink alcohol? If so, how much? _____ ❑Y ❑N
11. Have you ever sought professional care for drug abuse, alcoholism, or an emotional disorder? ❑Y ❑N
12. Do you have clicking or popping of your jaw joint? ❑Y ❑N
13. Do you have difficulty opening your mouth? ❑Y ❑N
14. Do you have any speech or hearing problems? ❑Y ❑N

I understand the importance of providing a truthful health history to assist my doctor in providing the best possible care. This information is complete and accurate.

Signature Date

Consent for Purposes of Treatment, Payment and Healthcare Operations

I have reviewed a copy of the Patient Notice of Privacy Practices, which describes how my protected health information may be used and disclosed. This notice is available in all offices, at www.ntfos.com and by request. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Northern Texas Facial & Oral Surgery. This Notice of Privacy Practices also describes my rights and the practice's duties with respect to my protected health information.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my doctor, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I consent to the use or disclosure of my protected health information as described in the Patient Notice of Privacy Practices by Northern Texas Facial & Oral Surgery, Drs. Hunter, Spingola, Buchmann, Brown, and Pace, its employees and staff for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct the health care operations of Northern Texas Facial & Oral Surgery. Healthcare operations may include email reminders, phone calls, and texts and correspondence asking for my feedback or inviting me to share my experiences via surveys and/or social media. I understand that diagnosis or treatment of me by Northern Texas Facial & Oral Surgery may be conditioned upon my consent as evidenced by my signature on this document. I authorize release of information to my immediate family members, including (as applicable) my parents or guardians, wife, husband, and children. Exceptions to this release are:

_____(none, if blank).

Northern Texas Facial & Oral Surgery doctors and/or staff may contact you to leave a detailed voicemail or text at the number on file in your records. If you do not wish for us to leave a detailed message, please indicate your preferences here: _____

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Northern Texas Facial & Oral Surgery is not required to agree to the requested restrictions. However, if my doctor agrees to a requested restriction, the restriction is binding. I have the right to revoke this consent, in writing, at any time, except to the extent that Northern Texas Facial & Oral Surgery, it's employees, doctors, and staff has taken action in reliance on this consent.

Northern Texas Facial & Oral Surgery reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing the website, calling the office and requesting a revised copy be sent in the mail or by asking for one at the time of my next appointment.

As a service to our patients, we may provide courtesy appointment reminder or other calls, emails and/or texts. By providing your cell phone number and email address, you consent to receiving such calls/emails/texts.

Signature of Patient or Personal Representative	Date
Name of Patient or Personal Representative	
Description of Personal Representative's Authority	

Surgical Facility Information
Notice Concerning Complaints

Surgical Facility Information

Thank you for the opportunity to provide your facial and oral surgery needs. We are committed to assuring your complete satisfaction.

David K. Hunter, DDS, Dean B. Spingola, DMD, MD, and Craig E. Buchmann, DDS have chosen to be owners in Irving Coppell Surgical Hospital and/or Trophy Club Medical Center. This ownership enhances their ability to direct the manner in which your care is delivered at the facility. If this is of concern to you, please feel free to discuss it with us. They are also on the medical staff at other healthcare facilities and will be happy to discuss your option of choosing an alternative location.

Notice Concerning Complaints

Complaints about physicians, as well as other licensees and registrants of the Texas State Board of Medical Examiners, including physician assistants and acupuncturists, may be reported for investigation at the following address:

Texas State Board of Medical Examiners
Attention: Investigations
333 Guadalupe, Tower 3, Suite 610
P.O. Box 2018, MC-263
Austin, Texas 78768-2018

Assistance in filing a complaint is available by calling the following telephone number: 1-800-201-9353

Complaints about Dental Surgeons may be directed to:
State Board of Dental Examiners:
Health Professions Council, (800) 821-3205, or
State Board of Dental Examiners
333 Guadalupe, Tower 3, Suite 800
Austin, TX 78701
(512) 463-6400

or, you may write a letter of complaint and mail it to the above address, or you may fax a complaint to 512-463-7452, or, you may email your complaint to complaints@tsbde.state.tx.us

Aviso Sobre Quejas

Se pueden presentar quejas acerca de médicos, así también como de otras personas autorizadas y registradas por la Junta de Examinadores Médicos del Estado de Texas (Texas State Board of Medical Examiners), incluyendo a ayudantes médicos y acupunturistas, para su investigación, en la siguiente dirección:

Texas State Board of Medical Examiners
Attention: Investigations
333 Guadalupe, Tower 3, Suite 610
P.O. Box 2018, MC-263
Austin, Texas 78768-2018

Se puede obtener ayuda para presentar una queja llamando al siguiente número telefónico: 1-800-201-9353

Insurance and Billing Policies

Important Information, please read carefully. Our goal is to insure you are well informed and to minimize financial surprises.

To help maximize your insurance savings, please provide us with your complete insurance information before the day of your visit. Your services may fall under your medical OR your dental policy, depending upon diagnosis, procedure, and policy requirements. We are happy to file a claim on your behalf. **We recommend that you learn the provisions of your insurance policy. All the information we receive is obtained verbally or online and is never a guarantee your insurance will pay.**

Sedation is provided for the patient's convenience and may not meet insurance policy requirements for coverage. If you elect to have sedation you are responsible for all associated fees.

Dental implants are normally not covered by insurance. Many policies which indicate "implant coverage" impose severe restrictions and therefore, in practical terms, do not cover them.

The parent requesting care (bringing the child to the appointment) is responsible for all charges incurred at that visit.

Please arrange to pay in full or to pay your estimated portion at the time of service for consultation services and at least one week prior for surgical services. Accounts with balances sent to insurance are due within 30 days of the service. If your insurance has not issued payment within that time, we suggest you contact them. Generally, these are the steps you can expect for surgery charges sent to insurance:

STEP ONE: Pre-surgery payment is due at least one week prior to procedure.
STEP TWO: Insurance processes claim and issues payment (if applicable)
STEP THREE: Payment of final balance. (As a convenience to you, we will process your credit card for any balance or refund due.)

When paying by credit card, your information is kept in our secure, encrypted file for balance due after insurance processes the claim. As the owner or person with signature rights, you agree that your credit card may be used for future services and balance due. This document suffices as written authorization until revoked in writing. For accounts with no valid credit card on file, a statement is sent as soon as insurance process the claim. Unpaid balances are due within 10 days of the statement date. After two statements (Statements are sent every 15-21 days.), accounts with outstanding balances are considered delinquent and processed for collection.

You authorize the release of medical or dental information necessary to process claims and you authorize payment of medical or dental benefits to Northern Texas Facial and Oral Surgery. Your benefit assignment does not take the place of your responsibility to pay for services received. Your account balance is due within 30 days regardless of insurance.

I have read the above, understand and agree.	Signature of Responsible Party	Date