Name: _____ Allergies: O Yes O No
Age: _____ Birthday: _____
Gender: O Male O Female
Using: O Dental Insurance O Cash
Patient ID: _____ Chart ID: _____
Medical ID: _____ Employer ID: _____
Member ID: _____ Carrier ID: _____
Contact via: ☐Email ☐Text Message ☐Phone Call
Main concern: _____

reliable
INTEGRITY • QUALITY • AFFORDABILITY
DENTISTRY

5228 Sycamore School Road #108, Fort Worth Texas 76123
(817) 900-9115
info@myreliabledentistry.com

NEW PATIENT REGISTRATION FORM

DENTAL QUESTIONNAIRE

Date of your last cleaning	_____	
Date of your last dental check up	_____	
Do your gums bleed while brushing or flossing?	O Yes	O No
Are your teeth sensitive to hot, cold or sweets?	O Yes	O No
Any specific problems with your teeth, gums, or mouth at this time?	O Yes	O No
Does food catch between your teeth?	O Yes	O No
Are you happy with your smile?	O Yes	O No
Do you experience popping, clicking or soreness when you open your mouth?	O Yes	O No
Do you have difficulty in opening your mouth widely?	O Yes	O No
Do you clench or grind your teeth?	O Yes	O No
Have you ever had orthodontic treatment? If Yes, date of placement	O Yes	O No
Do you have an unpleasant taste or odor in your teeth/mouth?	O Yes	O No
Do you want to learn to control your dental disease and retain your teeth?	O Yes	O No

PATIENT'S INFORMATION

First Name: _____ Last Name: _____ Middle Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Primary Phone: _____ Secondary Phone: _____
Email: _____ Gender: O Male O Female
Birthday: _____ Driver License: _____ SSN: _____
Preferred Pharmacy: _____
Material status: O Single O Married O Divorced O Separated O Widowed
Employment status: O Full time O Part time O Retired Occupation: _____
Student status: O Full time O Part time
Additional comment: _____

INSURED / RESPONSIBLE PARTY (if different from patient)

First Name: _____ Last Name: _____ Middle Name: _____
Address _____
City: _____ State: _____ Zip: _____
Primary Phone: _____ Secondary Phone: _____
Email: _____ Gender: O Male O Female
Birthday: _____ Driver License: _____ SSN: _____
Preferred Pharmacy: _____
Material status: O Single O Married O Divorced O Separated O Widowed
Employment status: O Full time O Part time O Retired Occupation: _____
Student status: O Full time O Part time
You are: O Patient's spouse O Patient's child O Patient's mother O Patient's father Other: _____
Additional comment: _____

PRIMARY INSURANCE INFO

Employer's Name: _____		Employer's Phone: _____	
Employer's address: _____			
City: _____	State: _____	Zip: _____	
Insurance Company: _____		Insurance Company Phone: _____	
Insurance Address: _____			
City: _____	State: _____	Zip: _____	
Primary holder is	○ Patient	○ Responsible Party (_____)	
Secondary holder is	○ Patient	○ Responsible Party (_____)	

MAIN CONCERN

☐ Toothache/Pain	☐ Gum Bleeding/Pain	☐ Bridge/Partial/Denture	☐ Invisalign/Braces
☐ Removal of Wisdom Teeth	☐ Chipped or Cracked Teeth	☐ Implants	☐ Other:
Additional Concern: _____			

WHO CAN WE THANK FOR YOUR VISIT WITH US TODAY?

☐ Drive/Walk by	☐ Mailer	☐ Transfer from Another Office	☐ Patient Referral
☐ Insurance Company	☐ Staff	☐ Online Search	☐ Other

_____

Are you Interested in ☐ 3rd party financing or ☐ Special offer (via text message/email)

MEDICAL HISTORY

Patient's Name: _____		Date: _____.
Are you under a physician's care now?	○ No	○ Yes, Explain: _____
Have you ever been hospitalized or had a major operation?	○ No	○ Yes, Explain: _____
Have you ever had a serious head or neck injury?	○ No	○ Yes, Explain: _____
Are you taking any medications, pills, or drugs?	○ No	○ Yes, Explain: _____
Do you take, or have you taken Phen-Fen or Redux?	○ No	○ Yes, Explain: _____
Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates?	○ No	○ Yes, Explain: _____
Are you on a special diet?	○ No	○ Yes, Explain: _____
Do you use tobacco?	○ No	○ Yes, Explain: _____
Do you use a controlled substance?	○ No	○ Yes, Explain: _____
Additional Information/Comments: _____		

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

☐ AIDS/HIV Positive	☐ Cortizone Medicine	☐ Osteoporosis	☐ Hepatitis A
☐ Alzheimer's Disease	☐ Diabetes	☐ Pain in Jaw Joints	☐ Tonsillitis
☐ Anaphylaxis	☐ Drug Addiction	☐ Parathyroid Disease	☐ Tuberculosis
☐ Anemia	☐ Easily Winded	☐ Hepatitis B or C	☐ Psychiatric Care
☐ Angina	☐ Emphysema	☐ Herpes	☐ Radiation treatments
☐ Arthritis/Gout	☐ Glaucoma	☐ High Cholesterol	☐ Recent Weight Loss
☐ Artificial Heart Valve	☐ Hay Fever	☐ Hives or Rash	☐ Renal Dialysis
☐ Artificial Joint	☐ Heart Attack/Failure	☐ Hypoglycemia	☐ Rheumatic Fever
☐ Asthma	☐ Heart Murmur	☐ Irregular Heartbeat	☐ Rheumatism

☐ Blood Disease	☐ Heart Pacemaker	☐ Kidney Problems	☐ Scarlet Fever
☐ Blood Transfusion	☐ Heart Trouble/Disease	☐ Leukemia	☐ Shingles
☐ Breathing Problems	☐ Hemophilia	☐ Liver Disease	☐ Sickle Cell Disease
☐ Bruise Easily	☐ Excessive Bleeding	☐ Low Blood Pressure	☐ Sinus Trouble
☐ Cancer	☐ Excessive Thirst	☐ Lung Disease	☐ Tumors or Growths
☐ Chemotherapy	☐ Fainting Spells/Dizziness	☐ Mitral Valve Prolapse	☐ Ulcers
☐ Chest Pains	☐ Frequent Cough	☐ Spina Bifida	☐ Veneral Disease
☐ Cold Sores/Fever Blisters	☐ Frequent Diarrhea	☐ Stomach/Intestinal Disease	
☐ Congenital Heart Disorder	☐ Frequent Headaches	☐ Stroke	☐ Yellow Jaundice
☐ Convulsions	☐ Genital Herpes	☐ Swelling of Limbs	
☐ Epilepsy or Seizures	☐ High Blood Pressure	☐ Thyroid Disease	

Are you allergic to any of these:

☐ Aspirin	☐ Codeine	☐ Metal	☐ Sulfa Drugs
☐ Penicillin	☐ Acrylic	☐ Latex	☐ Others:

Female patients, are you:

☐ Pregnant or Trying to Get Pregnant	☐ Taking Oral Contraceptives	☐ Nursing

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.

_____ _____

Print Patient's name / Parent or Guardian Date

_____

Signature

Dear Patient:

We would like to extend a very warm welcome to you! We sincerely appreciate you choosing Reliable Dentistry for your dental care and we look forward to getting to know you. If there is anything we can ever do to improve your experiences with us, please don't hesitate to ask.

This Welcome Letter includes several important documents to read and complete. Please remember to fill out the New Patient Registration Form and bring this to your first visit with us. Also bring any insurance information (member cards) you wish to utilize. You may send us your ID, driver license, and insurance card before your visit so that our staff can verify your insurance benefits for your convenience.

At this first visit, we will take time to discuss your dental goals and any concerns you have. We will then perform a comprehensive exam and take any necessary x-rays. With this information we can develop a customized dental plan together.

We have three important commitments in our practice. We have put them in writing because, as a practice we promise to always fulfill these commitments to you as a valued patient. Dr Nguyen and our team realize that these commitments may be different from what you may have been accustomed to in other dental practices; however, we believe that they are necessary in building the trust that it takes for us to successfully work together.

Commitment to Treatment

Dr. Nguyen and Reliable Dentistry team will deliver the best dental care that we are capable of delivering to you and will always stay current with the most successful treatment options available. Our office setting and technology will aim to increase patient comfort and the efficiency of the appointment, while achieving a successful outcome. We will listen and focus any recommendations around your personal desires, concerns, and goals. We ask that you care for your dental health to the best of your ability. Good daily home care is essential for dental health. Starting but not finishing treatment leads to more advanced disease which unnecessarily adds to your cost and limits the success of treatment. You can have great dental health by following through with your dental plan and home care.

Commitment to Appointment

We will reserve time especially for you in our schedule. We will give you our utmost attention and care and will rarely keep you waiting. An appointment scheduled in our office is a bond of trust that Dr. Nguyen and our team will be here to serve you and that you will be on time for your appointment.

Commitment to Financial Considerations

We have the responsibility to use our best professional care, skill, and judgment in helping you achieve your dental health goals. As a team we commit to give you up front information on finances; including cost, payment options, when the payment is expected (at or before time of service), and also any insurance coverage estimates.

Our office hours are Monday through Friday from 8:00AM – 5:00PM and every other Saturdays. Our office phone number is 817-900-9115. In the event of an emergency outside of our normal business hours, patients may also call our office number, one of our staff will assist you or contact the doctor on call for you.

Thank you and we look forward to seeing you soon!

Dr. Liem Nguyen and Reliable Dentistry Team

WRITTEN FINANCIAL POLICY

Thank you for choosing Reliable Dentistry. Our primary mission is to deliver the best and most comprehensive dental care available. The following is a statement of our Financial Policy, which you need to understand prior to treatment. If you have any questions, please feel free to ask.
We accept:

1. Cash and most major credit cards. There will be a $35.00 fee on all returned checks.
    a. We offer a 3% courtesy accounting adjustment to patients who pay for their treatment with cash prior to completion of care for treatment plans of $1000.00 or more.
2. CareCredit with 6-12 months payment plan. No annual fee or pre-payment penalties. Please ask us how.
3. Most major dental insurances

. We will file your insurance as a courtesy to you, but we do expect your estimated payment and necessary deductible to be paid at the time of service. The estimated co-payment is merely an estimate and not a guarantee of payment by your insurance company. You must provide name, address and phone number of your insurance company in order for us to submit a claim form. If not provided, you will be required to pay for your visit in full and your insurance company will reimburse you. After 60 days any unpaid balance becomes your responsibility and is subject to collection process. We charge 3% interest on all past due accounts.

4. Reliable Dentistry requires payment prior to the beginning of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.
5. Also, we reserve the right to charge for appointments canceled or broken without 24 hours advance notice. Please refer back to Broken Appointment Policy for more details.

Payment must be **PAID IN FULL** at the time of service completed.
REGARDLESS OF WHAT YOUR INSURANCE COMPANY PAYS, YOU REMAIN FULLY RESPONSIBLE FOR PAYMENT OF YOUR BILL.

Print Patient's name / Parent or Guardian

Date

Signature

BROKEN APPOINTMENT POLICY

Reliable Dentistry value you as our patient and need your cooperation with keeping appointments so that we can provide your care. Missing or late canceling an appointment means we are unable to fill this appointment time with another patient who desperately needs care.

Our policy requires:

1. **Timely Cancellations**: If you need to cancel or reschedule your appointment, you must give us at least 24 hours' notice. Cancellations made with less than 24 hours' notice will be considered a missed appointment.
2. **On Time Arrivals**: If you are more than 15 minutes late to your appointment, we will give your appointment away to another patient. This will be considered a missed appointment.
3. **$50 Penalty Fee** will be applied when you fail to give sufficient warning to keep a scheduled appointment or fail to show up to your appointment. This fee will be paid within 30 days to prevent collection procedures. The patient/parent/legal guardian is responsible for the payment of the charge.

Please feel free to discuss this and other policies with our staff. Do not hesitate to call our office if you have any questions. 817-900-9115

Print Patient's name / Parent or Guardian

Date

Signature

NOTICE OF PRIVACY PRACTICES

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 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 the 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 retain, 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:
Treatment: we may use or disclose your health information to a physician or other healthcare provider providing treatment to you.
Payment: we may use and disclose your health information to obtain payment for services we provide to you.
Healthcare operations: 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. Your authorization 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.
To your family and friends: 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 our agree
that we may do so.
Persons involved in care: 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 ill 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.
Marketing health-related services: We will not use your health information for marketing communications without your written authorization.
Required by law: we may use or disclose your health information when we are required to do so by law.
Abuse or neglect: we may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, 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 of the health or safety of others.
National security: 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 officials having lawful custody of protected health information of inmate or patient under certain circumstances.
Appointment reminders: 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 to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. 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. If you requested copies, we have the right to charge you $0.05 for each page, $15.00 per
hour for staff time to locate and copy 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.
Disclosure accounting: you have the right to receive a list of instances in which we or our business associates disclosed your heath 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.
Restriction: you have the right to request that we place additional restrictions on our use of 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.
Alternative communication: you have the right to request that we communicate with your 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 a satisfactory explanation of how payments will be handled under the alternative means or location you request.
Amendment: 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.
Electronic notice: if you receive this Notice on our web site or by electronic main (email), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact our office!
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.

Print Patient's name / Parent or Guardian

Date

Signature