WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions or need assistance completing the form, please feel free to ask our employees. We look forward to working with you in maintaining your dental health.

Patient Information

Name _____ Soc. Sec. # _____
Last Name *First Name* *Initial*

Address _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Sex ___ M ___ F Age _____ Birthdate _____ ___ Single ___ Married ___ Widowed

Patient Employed by _____ ___ Separated ___ Divorced

Business Address _____ Business Phone _____

Business Email _____ Occupation _____

Whom may we thank for referring you? _____

Notify in case of emergency _____ Home Phone _____

Cell Phone _____ Business Phone _____

Email _____

Primary Dental Insurance

Person Responsible for Account _____
Last Name *First Name* *Initial*

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (if different from patient) _____ Home Phone _____

City _____ State _____ Zip _____

Cell Phone _____ Email _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company _____ Insurance Phone _____

Insurance Email _____

Contract # _____ Group # _____ Subscriber ID# _____

Name of other dependents under this plan _____

Dental History

What would you like us to do today? _____ Are you in dental discomfort today? _____

Former Dentist _____ Address _____

Dentist's Email _____ Phone _____

Date of last dental care _____ Date of last x-rays _____

Check ( ) yes or no if you have had problems with any of the following:

(Y) (N) Bad Breath	(Y) (N) Food collection between teeth	(Y) (N) Periodontal treatment	(Y) (N) Sensitivity to sweets
(Y) (N) Bleeding Gums	(Y) (N) Grinding or clenching teeth	(Y) (N) Sensitivity to cold	(Y) (N) Sensitivity when biting
(Y) (N) Clicking or popping jaw	(Y) (N) Loose teeth or broken fillings	(Y) (N) Sensitivity to hot	(Y) (N) Sores or growths in mouth

How often do you brush? _____ Floss? _____

How do you feel about the appearance of your teeth? _____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? (Y) (N)

Other information about your dental health or pervious treatment _____

AUTHORIZATION

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge.
I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

Payment is due in full at time of treatment, unless prior arrangements have been approved.

Health History

Name _____ Date Of Birth: _____ **Date:** _____
Last Name *First Name* *Initial*

SYMPTOMS Check (✓) symptoms you currently have or have had in the past year.

GENERAL
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE
Pain, weakness, numbness in:
- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision - Flashes
- ☐ Vision - Halos

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN only
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other _____

WOMEN only
- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other
- ☐ Date of last
- ☐ menstrual period
- ☐ Date of last Pap Smear

Have you had a mammogram? _____
Are you pregnant? _____
Number of children? _____

CONDITIONS Check (✓) conditions you currently have or have had in the past year.
- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsilitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

OTHER CONDITIONS (Not mentioned above): _____

MEDICATIONS List medications you are currently taking.	**ALLERGIES To** medications or substances
Pharmacy Name Phone	

Print Patient Name: _____ Signature: _____ Date: _____

Family History

Name: _____ **Date Of Birth:** _____ Date: _____

All information is strictly confidential.

FAMILY HISTORY Please fill in health information about your immediate family.

Relation	Age	State of Health	Age at Death	Cause of Death	Check (✓) if, your blood relatives had any of the following: Disease	Relationship to you
Father						Arthritis, Gout
Mother						Asthma, Hay Fever
Brothers						Cancer
						Chemical Dependency
						Diabetes
						Heart Disease, Strokes
Sisters						High Blood Pressure
						Kidney Disease
						Tuberculosis
						Other

HOSPITALIZATIONS

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transusion? ( ) Yes ( ) No

SERIOUS ILLNESS / INJURIES	DATE	OUTCOME

PREGNANCY HISTORY

Birth Yr	Sex of Birth	Complications if any

HEALTH HABITS Check (✓) which substances you use and describe how much you use.

	Caffeine	
	Tobacco	
	Street Drugs	
	Other	

OCCUPATIONAL CONCERNS Check (✓) if your work exposes you to the following:

	Stress
	Hazardous Substances
	Heavy Lifting
	Other:

Your Occupation:

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Paret, Guardian or Personal Representative — Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

_____ _____

Reviewed By — Date

Herbal Supplements

Patient Name _____

Herbal supplements are a wonderful way to enhance your health but they can have an impact on dental medications, procedures and healing after surgery. For this reason, we would like to know if you are taking any of the supplements listed below, especially in large doses. Please check the box next to those that apply and note the dosage, approximately, on the line next to it. Thank you!

☐ Diet or Energy Supplements _____ per day

☐ Garlic _____ per day

☐ Ginger _____ per day

☐ Ginseng_____ per day

☐ St. John's Wort _____ per day

☐ Vitamin E _____ per day

☐ Echinacea _____per day

☐ Ginkgo _____per day

☐ Kava _____ per day

☐ Valerian _____ per day

☐ Fish Oil _____ per day

Do you regularly use natural or herbal **oral** health products? If yes, which ones?

_____

_____

Have you recently substituted herbs for prescription or "over the counter" drugs?
If yes, please let us know on the lines provided.

_____

_____

_____ _____

Signature **Date**

Dental Priorities Questionnaire

Please rate the following in importance:

One (1) being of the lowest importance to five (5) being the highest of importance.

		Lowest ⟺ Highest				
		1	2	3	4	5
A	Having no dental pain	○	○	○	○	○
B	Preserving my teeth for a lifetime	○	○	○	○	○
C	Having no gum disease	○	○	○	○	○
D	Being able to chew my food well	○	○	○	○	○
E	Having healthy gums	○	○	○	○	○
F	Having a beautiful smile because of my teeth	○	○	○	○	○
G	Having bright white teeth	○	○	○	○	○
H	Having no infections in my teeth or gums	○	○	○	○	○
I	Having straight looking teeth	○	○	○	○	○
J	Having no tooth decay	○	○	○	○	○
K	Preventative maintenance regarding my teeth	○	○	○	○	○
L	Being able to keep my teeth clean	○	○	○	○	○

Which of the above stays in your mind as the most important?

(circle one) A B C D E F G H I J K L

Second most important?

(circle one) A B C D E F G H I J K L

Margaret Elizabeth Rayne, D.D.S.

1221 W. Ben White Blvd., Suite 112A ♦ Austin, TX 78704 ♦ (512) 443-5813

Broken Appointment Policy—please read carefully and sign

♦RESERVED APPOINTMENT TIME IN ANY DENTAL OFFICE IS LIMITED AND VALUABLE♦
We do not overbook our schedule and it is therefore extremely important that all patients honor their reserved appointments. Failure to do so deprives our other patients of timely completion of their needed dental care and incurs unacceptable overhead expense to the office that cannot be recovered.

So that other patients and our staff will not be penalized by those who fail to keep scheduled appointments, or **those who are 15 minutes late or more**, our office policy stipulates that **failure to give AT LEAST 48 HOURS advance notice will result in a fee being charged**. That charge is in accordance with our broken appointment policy for ALL patients and is to be paid PRIOR to the scheduling of any new appointment.

In addition, we attempt to confirm appointments 1-2 days ahead of time as a courtesy to our patients. However, you are ultimately responsible for the appointments you make with our office. If we are unable to confirm an appointment for any reason you are still responsible for keeping your appointment.

The office fee for broken appointments is $50.00 per half-hour and $100.00 per hour of reserved time. This fee does not cover actual overhead expenses, but it helps.

Privacy Policies

Our office strives to protect the personal information of each of our patients. We have a set of privacy policies that govern our use of your personal health information. A copy of these policies is available for your review in our lobby.

_____

Print Patient Name

_____ _____

Patient Signature **Date**

Policy on Insurance

We accept any insurance plan that allows you to choose your own provider; however we are not an in-network provider for any insurance companies. That means, we are able to file your insurance for you and will accept assignment (have your insurance pay us directly) if your plan allows.

Many insurance companies (such as Delta Dental plans other then Delta Dental of TX or GA) pay patients directly. If that is the case, the full cost of your treatment is due at the time of your appointment. Our office does not offer payment plans, but we welcome you to apply for Care Credit if you need such an arrangement.

As an out-of-network provider we do not agree to a reduced fee for our services as well as are not given access to pertinent information regarding the parameters of the plan set up by you or your Human Resources department. Therefore, we can only give you an estimate as to what your insurance will pay and cannot guarantee any payment. We are happy to provide you with the ADA codes for the treatment you require. You may contact your insurance company directly with these codes to obtain more detailed coverage information.
Your account is solely your responsibility-whatever your insurance company does not pay is due immediately. If your account is not paid immediately we reserve the right to send your account to a collections agency any and all collections fees are also your sole responsibility.

We appreciate your understanding and adherence to this policy.

_____
Print Patient Name

_____ _____
Patient Signature Date

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.
MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

_____ _____

Please ***print*** name of Patient Please ***sign*** for Patient / Guardian of Patient

_____ _____

Legal Representative / Guardian Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents: _____

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:
☐ First Name Only ☐ Proper Sur Name ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

☐ Phone Message
☐ Text Message
☐ Email
☐ **Any of the Above**
☐ **None of the above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment ____
I could not communicate with the patient ____
The patient refused to sign ____
The patient was unable to sign because ____
Other (please describe) ____

_____
Signature of Privacy Officer

Authorization to Release PHI (Protected Health Information)

Access, Inspect and/or Copy

Patient's Name: _____ Date of Birth: _____

Doctor: _____

Practice Name: _____ Phone Number: _____

I request and authorize the above listed doctor and practice to release health care information of the patient named above to:

Name: Margaret Elizabeth Rayne, DDS, PC
Address: 1221 W. Ben White Blvd., Suite 112A
City, State: Austin, Texas Zip Code: 78704

Email: info@naturaltoothfairy.com Phone: 512-443-5813 Fax: 512-443-5904

This request and authorization applied to health care information relating to the following treatment, condition, or dates of treatment:

_____

_____

Or _____ All health care information
Or _____ Other: _____

_____

Please send patient X-Rays prior to the following appointment date: _____

Once my doctor gives out the information that I want released, I know that my doctor has no control over the information. The individual or organization that I authorized to receive the information might re-disclose it. Federal or State privacy laws may no longer protect the information.

_____ _____

Signature of patient or patient's authorized representative Date Signed

_____

Relationship or status if signed by parent, legal guardian, or personal representative, etc