Crown Pointe Dentistry, PA
Chad Drennan, DDS & Mike Drennan, DDS
817-441-7654

Patient Registration

Please answer all questions completely- Please print.

PERSONAL INFORMATION Date: _____

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Cell Phone: _____

Birth Date: _____ Sex:_____ Please Circle One: Minor Single Married

Occupation: _____ Business Phone: _____

Employed By: _____ How Long: _____

Employers Address: _____

City: _____ State: _____ Zip Code: _____

Social Security #: _____ Drivers License #: _____

Spouse's Name (Parent if patient is a Minor): _____

Spouse's Occupation: _____Spouse's Phone #: _____

DENTAL INSURANCE INFORMATION

Name of Insured: _____ Relationship to Patient: _____

Birth Date: _____ Social Security #: _____ Work Phone #: _____

Employer & Address: _____

City & State: _____ Zip Code: _____ Insurance Company: _____

Insurance Address: _____ City, State & Zip: _____

Group #: _____ Insurance Phone #: _____

Do you have additional dental insurance? _____

Authorization

I authorize that as long as the office of Crown Pointe Dentistry, PA keeps this document on file, the office may use it to represent my consent for filing insurance claims. Unless restricted by my insurance policy, payment of insurance benefits, otherwise payable to me, will be made directly to Crown Pointe Dentistry, PA. I authorize release of information relating to these claims.

I authorize my dental insurance company to release benefit and/or claim information to Crown Pointe Dentistry, PA.

This will serve as my consent for general treatment. This consent is effective until such date as I cancel this consent in writing. My signature below signifies that I have read and understand this authorization.

_____ _____

Patient/Parent Signature Date

Patient Name: _____
Date: _____ Phone #: _____
Date of Birth: _____

DENTAL HISTORY INFORMATION

Previous Dentist Name: _____

City & State: _____ Phone #: _____

How long has it been since you have seen a dentist? _____

Last complete dental exam date: _____

Last full mouth x-rays date: _____

Are you having problems now? ☐ Yes ☐ No

If "Yes," please list: _____
Referred By: _____

Do you wear dentures? (Partials or Full – Circle One)	☐ Yes ☐ No
Are you unhappy with your dentures?	☐ Yes ☐ No
Have you had periodontal (gum) treatments?	☐ Yes ☐ No
Do your gums bleed, or feel tender, or irritated?	☐ Yes ☐ No
Are your teeth sensitive to hot, cold, sweets, or pressure?	☐ Yes ☐ No
Are you unhappy with the appearance of your teeth?	☐ Yes ☐ No
Are you aware of grinding or clenching your teeth?	☐ Yes ☐ No
Do you have headaches, earaches, or neck pains?	☐ Yes ☐ No
Do you have loose, chipped, or shifting teeth?	☐ Yes ☐ No
Have you worn braces on your teeth? (Orthodontics)	☐ Yes ☐ No
Do you have discolored teeth that bother you?	☐ Yes ☐ No
Would you like your smile to look better or different?	☐ Yes ☐ No
Do you have problems with teeth/fillings breaking?	☐ Yes ☐ No
Do you regularly use dental floss?	☐ Yes ☐ No
Do you experiment with recreational drugs?	☐ Yes ☐ No
Are you aware of being allergic to or reacting adversely to any medications or substances?	☐ Yes ☐ No

If "Yes," please list: _____
_____

Crown Pointe Dentistry
Dr. Chad Drennan & Dr. Mike Drennan

MEDICAL HISTORY INFORMATION

Do you have any current health problems?	☐ Yes ☐ No
Are you under a physician's care now?	☐ Yes ☐ No
If "Yes," for what? _____	
Are you currently taking any medications?	☐ Yes ☐ No
If "Yes," please indicate: _____	
_____	
Are you Pregnant?	☐ Yes ☐ No
Do you use tobacco products?	☐ Yes ☐ No
Family Physician's Name: _____	
City/ State: _____ Phone: _____	

Check any of the following which you currently have or have had in the past

☐ Heart Attack	☐ Heart Disease	☐ Angina Pectoris
☐ High Blood Pressure	☐ Heart Murmur	☐ Rheumatic Fever
☐ Congenital Heart Lesions	☐ Scarlet Fever	☐ Artificial Heart Valve
☐ Heart Pacemaker	☐ Heart Surgery	☐ Artificial Joint/Hip/Knee
☐ Anemia	☐ Stroke	☐ Kidney Trouble
☐ Ulcers	☐ Cosmetic Surgery	☐ Hepatitis A (infectious)
☐ Hepatitis B (serum)	☐ Liver Disease	☐ Yellow Jaundice
☐ Blood Transfusion	☐ Drug Addiction	☐ Hemophilia
☐ Fever Blisters	☐ Epilepsy or Seizures	☐ Fainting or Dizzy Spells
☐ Nervousness	☐ Psychiatric Treatment	☐ Sickle Cell Disease
☐ Glaucoma	☐ Chemotherapy (Cancer/ Leukemia)	☐ Venereal Disease (Syphilis, Gonorrhea, etc)
☐ Tuberculosis (TB)	☐ Asthma	☐ Hay Fever
☐ Sinus Trouble	☐ Allergies or Hives	☐ Diabetes
☐ Thyroid Disease	☐ X-Ray/Cobalt Treatment	☐ Arthritis
☐ Rheumatism	☐ Cortisone Medications	☐ Pain in Jaw Joints
☐ Alcoholism	☐ Bleeding Problems	☐ Pneumonia
☐ Bruise Easily	☐ Emphysema	☐ Alzheimer's

Medical Alerts

☐ Allergic to Aspirin	☐ Allergic to Penicillin	☐ Pre-medication Required
☐ Allergic to Codeine	☐ HIV Positive	☐ Latex Allergy
☐ Mitral Valve Prolapse	☐ Prior Hepatitis	
☐ Heart Problems	☐ Other (list below)	

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Patient Signature _____

Date _____

CROWN POINTE DENTISTRY, P.A.
Financial Arrangements

Welcome to our practice,

From the moment you walk through our door you will notice that our goal is to make you feel at home in our pleasant, relaxed atmosphere. Our friendly staff will take special care to make certain that you are comfortable and well cared for.

We provide advanced dental care, and have dedicated our practice to excellence in painless dentistry. Your dental health is of the utmost importance to us. We will educate and counsel you on all procedures that you may require. Our staff is prepared to help train our patients in preventive dental care and proper hygiene.

We look forward to a long term professional relationship with people such as you; to this end we have prepared the following so that you know what is expected of you, and we welcome you to our practice.

Payment Responsibilities:
Payment is due at the time services are rendered, unless payment arrangements have been approved in advance. For your convenience we accept MasterCard, Visa, Discover, American Express & Care Credit. Returned checks and balances older than 30 days will be subject to additional collection fees and interest charges. Charges may also be assessed for repeated missed appointments without a 24 hour advanced notice.

Insurance Policy:
We will file with your insurance company, but all patient portions are due at the time of service. Patient portions are calculated based on information we receive from your insurance company.

However, your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. Our fees are generally considered within the acceptable range by most companies and therefore are covered up to the maximum allowance determined by each carrier. Not all services, however, are a covered benefit in all contracts.

We must emphasize that as dental care providers our relationship is with you- not your insurance company. All charges are you responsibility from the date the services are rendered.

I have read and understood the above financial policy.

Signature:_____

ACKNOWLEDGE OF PRIVACY PRACTICES-HIPAA

The Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

Provide & coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.

Obtain payment from third-party payers for my health services. Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my dental provider's Notice of Privacy Practices contain a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand that my dental provider has the right to change the Notice of Privacy Practices and that I may contact this office at the address above to obtain a current copy of the Notice of Privacy Practices.

At times we will need to contact you concerning information that is specific to you, your treatment and your dental needs. Information that is requested to be sent to you, or on your behalf, by our office via email will be sent in standard email format. We do not have encrypted services available for such communication. We may have the need to use the telephone for confirmation of appointments or verification of health/dental needs. We will remain mindful all HIPAA laws concerning release of information in these instances.

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 and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

_____

Patient's Printed Name

_____

Patient/Guardian's Signature Date

Please list below anyone who the patient allows to receive information about their dental needs.

_____

_____

Contact Officer: Dr. Chad Drennan

Telephone: 817-441-7654 Fax: 817-441-6168

Address: 220 Shops Blvd. Willow Park, TX 76087