HDentaL
A Dentist Geared to You

New Patient Registration Form

13119 Louetta Rd, Cypress, TX 77429 832-698-4648

Last name _____ First _____ MI ____ Preferred name _____
Sex ☐ Male ☐ Female Marital Status ☐ Single ☐ Married ☐ Child ☐ Other _____
Birthdate (MM/DD/YYYY) _____ SSN _____ Driver License # _____
Address _____ City _____ State _____ Zip _____
Mobile # _____ Work # _____ Email _____
Employer name _____ Occupation_____

We TEXT reminders, please let us know if (STOP)

Emergency Contact _____ Relation to Pt _____ Phone # _____
Whom may we thank for referring you? ☐ Friend _____ ☐ Google ☐ Facebook
☐ Magazine ☐ Flyer ☐ Drove by ☐ Other _____

NO SHOW/CANCELLATION POLICY

Your appointment time is set-aside especially for you. We ask as a courtesy to the Doctor and other patients that you keep your scheduled appointments. If you must change or miss an appointment, we require 48-hour notice. Cancellations, last minute rescheduling or failure to show will result in a broken appointment charge of $35 or no reappointment. This policy is strictly enforced.
I hearby acknowledge the **above** provided to me by HUYLAMDDS, PLLC (DBA HDentaL) including calling 48 hours ahead to avoid the No-show/Cancellation fee of $35.

Signature: _____ Date: _____
Patient or Parent/Guardian Signature if minor.

I hearby acknowledge **receipt** of the **Notice of Privacy Practice (HIPAA Acknowledgement)** given to me by HUYLAMDDS, PLLC (DBA HDentaL). I understand that I may inspect or copy the protected health information described by this authorization. I understand at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other actions have been taken in reliance on an authorization I have signed. I understand that my healthcare and the payment for my healthcare will not be affected if I refuse to sign this form. I understand that information used or disclosed, pursuant to this authorization, could be subject to redisclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

Signature: _____ Date: _____
Patient or Parent/Guardian Signature if minor.

Reason for Today's Visit _____
Former Dentist _____ Date of last dental care _____
I routinely see my dentist every ☐ 3 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

Check (√) if you have or have had any of the following:

☐ Bad breath	☐ Grinding teeth	☐ Had/have braces, orthodontics
☐ Bleed gums	☐ Growths in mouth	☐ Loose teeth/broken fillings
☐ Clicking or popping jaw	☐ Had any reactions to local anesthetics	☐ Periodontal treatment
☐ Complications from past dental treatment	☐ Had any teeth removed	☐ Sensitivity to cold/hot
☐ Food collection between teeth	☐ Had trouble getting numb	☐ Sores or ulcers

How often do you floss? _____
How often do you brush? _____
What type of toothbrush do you use? ☐ Electric ☐ Manual

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Physician's Name _____ Date of last visit _____
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 _____
Presently being treated for any other illnesses? ☐ Yes ☐ No If yes, give details_____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Lonimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and redux (dexfenfluramine). ☐ Yes ☐ No

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (√) if you take antibiotic pre-medication for your dental visits:
☐ Pre-Med - Amoxicillin ☐ Pre-Med – Clindamycin ☐ Pre-Med Other _____
PRE-MED patients: Please list why Pre-Med is needed:
_____
_____

Check (√) if you have or have had any of the following:

☐ Alzheimer's	☐ Cough up Blood	☐ HIV/AIDs	☐ Shortness of Breath
☐ Anemia	☐ Cough, Persistent	☐ Jaundice	☐ Sinus Problems
☐ Anxiety/Depression	☐ Diabetes	☐ Jaw Pain	☐ Sjogren's Syndrome
☐ Arthritis, Rheumatism	☐ Dizziness	☐ Kidney Disease	☐ Skin Rash
☐ Artificial Heart Valves	☐ Epilepsy	☐ Liver Disease	☐ Smoke/previously smoked
☐ Artificial Joints	☐ Excessive bleeding	☐ Mental Disorders	☐ Stroke
☐ Asthma	☐ Fainting	☐ Mitral Valve Prolapse	☐ Stomach Problems
☐ Back Problems	☐ GERD/Acid Reflux	☐ Nervous Disorders	☐ Swelling of Feet or Ankles
☐ Blood Disease	☐ Glaucoma	☐ Osteoporosis	☐ Thyroid Problems
☐ Cancer	☐ Headaches	☐ Osteoporosis Meds	☐ Tonsillitis
☐ Celiac Disease	☐ Heart Disease	☐ Pacemaker	☐ Transplant
☐ Chemical Dependency	☐ Heart Murmur	☐ Radiation Treatment	☐ Tuberculosis
☐ Chemotherapy	☐ Hemophilia	☐ Respiratory Disease	☐ Tumors
☐ Circulatory Problems	☐ Hepatitis	☐ Rheumatic Fever	☐ Ulcer
☐ COPD	☐ High Blood Pressure	☐ Rheumatism	☐ Venereal Disease
☐ Cortisone Treatments	☐ High Cholesterol	☐ Scarlet Fever	☐ Other _____

Medications (list medications you are currently taking) _____
Allergies ☐ Aspirin ☐ Codeine ☐ Erythromycin ☐ Penicillin ☐ Sulfa ☐ Latex ☐ Other _____

If there have been any medical changes since your last visit with us, please list below.
_____
_____

List all medications, drugs, pill or herbal remedies, including regular dosages of aspirin.
_____
_____
_____

☐ ***By checking this box, I acknowledge that the above information is correct, and I understand that it is my responsibility to inform the office of any changes in my health as soon as possible. I will not hold my doctor or any members of his staff responsible for any errors or omissions that I may have made in completion of this form.***

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I certify that I, and/or my dependent(s), have insurance coverage and assign directly to HUYLAMDDS, PLLC (DBA HDentaL) all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance.

Insurance Company Name _____ Policy ID # _____ Group # _____

Primary Policy Holder Name and DOB _____

I authorize HUYLAMDDS, PLLC (DBA HDentaL) which includes its Dentist and Dental Staff to the following:

- I authorize the use my electronic signature on all insurance submissions.
- I authorize my insurance to pay my benefits directly to the dentist for all services rendered.
- 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.

The above-named entity may use my health care information and may disclose such information to the above-named Insurance Company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

I understand that I can revoke this authorization at any time with a signed written consent except to the extent that the covered entity has already acted in reliance upon the authorization and/or for the purpose of obtaining payment for the covered transactions.

Signature: _____ Date: _____

Patient or Parent/Guardian Signature if minor.