FINLEY AND RUNYAN, D.D.S., L.L.P.

PATIENT REGISTRATION

First Name:______________________ Last Name:______________________ Middle Initial:______

Patient Is: ☐ Policy Holder   Preferred Name:______________________

☐ Responsible Party

Responsible Party (if someone other than the patient)

First Name:______________________ Last Name:______________________ Middle Initial:______

Address:______________________ Address 2: ______________________

City, State, Zip:______________________ Pager:______________________

Home Phone:__________ Work Phone:__________ Ext: ______ Cellular: __________

Birth Date:__________ Soc. Sec:__________ Driver's Lic: __________

◯ Responsible Party is also a Policy Holder for Patient ◯ Primary Insurance Policy Holder ◯ Secondary Insurance Policy Holder

Patient Information

Address:______________________ Address 2: ______________________

City:______________________ State / Zip: _________ __________ Pager: __________

Home Phone:__________ Work Phone:__________ Ext:______ Cellular:__________

Sex: ◯ Male ◯ Female   Marital Status ◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed

Birth Date:__________ Age:______ Soc. Sec:__________ Drivers Lic:__________

E-mail: ______________________ ☐ I would like to receive correspondence via e-mail.

Section 2

Employment Status: ◯ Full Time ◯ Part Time ◯ Retired

Student Status: ◯ Full Time ◯ Part Time

Medicaid ID: ______________________ Pref. Dentist:______________________

Employer ID: ______________________ Pref. Pharmacy:______________________

Carrier ID: ______________________ Pref. Hyg.:______________________

Primary Insurance Information

Name of Insured:______________________ Relationship to Patient: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec.:__________ Insured ID #:__________ Insured Birth Date: __________

Employer:______________________

Address:______________________

Address 2:______________________

City, State, Zip: ______________________

Ins. Company:______________________

Address:______________________

Address 2:______________________

City, State, Zip:______________________

Rem. Benefits__________.00 Rem. Deduct:__________.00

Secondary Insurance Information

Name of Insured:______________________ Relationship to Patient: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec.:__________ Insured ID #:__________ Insured Birth Date: __________

Employer:______________________

Address:______________________

Address 2:______________________

City, State, Zip: ______________________

Ins. Company:______________________

Address:______________________

Address 2:______________________

City, State, Zip:______________________

Rem. Benefits__________.00 Rem. Deduct:__________.00

Time 8:22 AM

FINLEY _RUNYAN, LLP

Date 7/15/2016

Patient Medical History Form

Patient Name: Birth Date: Date Created:

Are you being treated by a physician now? ◯ Yes ◯ No If yes

Have you been hospitalized or had any operations? ◯ Yes ◯ No If yes

Are you taking any prescription or over-the-counter medications? Please provide list or write: ◯ Yes ◯ No If yes

Have you ever taken Phentermine, Redux, Fosamax, Boniva, Actonel or any medications containing ◯ Yes ◯ No If yes

Do you use controlled substances? ◯ Yes ◯ No If yes

Women, are you currently:

- ☐ Pregnant
- ☐ Trying to get pregnant
- ☐ Nursing
- ☐ Taking oral contraceptives

Are you allergic to any of the following?

- ☐ Aspirin
- ☐ Acrylic
- ☐ Sulfa Drugs
- ☐ Penicillin
- ☐ Metal
- ☐ Local Anesthetics
- ☐ Codeine
- ☐ Latex

Any other allergies? ◯ Yes ◯ No If yes

DO YOU HAVE OR HAVE YOU HAD:

- ☐ AIDS/HIV Positive
- ☐ Alzheimer's/Dementia
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Hemophilia
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve
- ☐ Heart Disease
- ☐ Heart Attack/Defects
- ☐ Heart Murmur
- ☐ Mitral Valve Prolapse
- ☐ Asthma, TB, Emphysema
- ☐ Stroke/Hardening of Arteries
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ High Cholesterol
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Liver Disease
- ☐ Stomach Problems/Ulcers
- ☐ Diabetes
- ☐ Tumors or Cancer
- ☐ Kidney or Bladder Disease
- ☐ Renal Dialysis
- ☐ Thyroid/Parathyroid Disease
- ☐ Blood Disease
- ☐ Cold Sores/Fever Blisters
- ☐ Venereal Disease/STD
- ☐ Irregular Heartbeat
- ☐ Pacemaker
- ☐ Rheumatism
- ☐ Herpes
- ☐ Spina Bifida

HAVE YOU RECENTLY EXPERIENCED:

- ☐ Chest Pain/Angina
- ☐ Breathing Problems
- ☐ Frequent Cough
- ☐ Recent Weight Loss
- ☐ Bruising Easily
- ☐ Hay Fever
- ☐ Sinus Problems
- ☐ Epilepsy/Seizures
- ☐ Excessive Thirst
- ☐ Frequent Urination
- ☐ Frequent Diarrhea
- ☐ Excessive Bleeding
- ☐ Frequent Headaches
- ☐ Fainting/Dizziness
- ☐ Recent Weight Loss/Gain

DO YOU HAVE OR HAVE YOU HAD:

- ☐ Radiation Treatment
- ☐ Psychiatric Care
- ☐ Chemotherapy
- ☐ Artificial Joint
- ☐ Blood Transfusion
- ☐ Cortisone Medicine
- ☐ Glaucoma
- ☐ Osteoporosis
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Tonsillitis
- ☐ Hypoglycemia/Hyperglycemia
- ☐ Swelling of Limbs

PLEASE CHECK THE APPROPRIATE ANSWER:

- ☐ Are you currently taking blood thinners?
- ☐ Are you required to pre-medicate by a Dr
- ☐ Do you use tobacco?
- ☐ Are you on a special diet?

Do you have any other conditions not included on this form? Please list. ◯ Yes ◯ No If yes

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 health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date:___________

FINLEY AND RUNYAN, D.D.S., L.L.P.

DENTAL HISTORY

For your safety and to assist us in accurately diagnosing and treating you, please carefully review this form completely and fill out all areas which pertain to you. ALL INFORMATION IS KEPT CONFIDENTIAL

Patient Name: ____

Dental History:

Previous Dentist________________________________City________________________How long____________________

Date of last visit______________Date of last dental cleaning___________Date of last full mouth x-ray ______________

1. Have you ever had any serious trouble associated with previous dental treatment? ____Yes ____No
2. Does dental treatment make you nervous? ____Yes ____No
3. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? ____Yes ____No

Check any of the following you have had or currently have:

___Mouth Discomfort
___Serious injury to head or mouth
___Gums Bleed when Brushing
___Gums Bleed when Flossing
___Grind or Clench your teeth
___Pain, Clicking, Popping in Jaw Joints
___Orthodontic Treatment
___Does food or floss catch between your teeth
___Awake with Sore Jaws
___Dentures or Partials
___Immediate Relatives that have lost all of their Natural Teeth

___Mouth Odor or Bad Taste
___Cold Sores or Fever Blisters
___Loose or Shifting Teeth
___Trouble Chewing/Speaking
___Sensitive Teeth (Hot, Cold, Sweets, Pressure)
___Snoring
___Trouble Breathing while Sleeping
___Dry Mouth
___Earaches or Neck pain
___Participate in active recreational activities
___Complications with or following previous Dental or Oral Surgical treatment

What is the reason for your dental visit today? ____

How do you feel about your smile? ____

Who may we thank for referring you to our office? ____

Finley & Runyan, LLP

Chance W. Finley, D.D.S.
Clayton Z. Runyan, D.D.S.
2201 South Danville Drive
Abilene, Texas 79605
(325) 692-6031

FINANCIAL POLICY

DENTAL BENEFIT PLAN POLICY

I understand the design of my dental plan may limit my benefits. Finley & Runyan, LLP cannot guarantee the information disclosed to them is accurate. The most accurate information regarding my dental plan is found in my benefit booklet. I understand that my dental benefit plan is an agreement between my insurance company and me. I also understand that I am responsible for my balance regardless of my dental plan.

AUTHORIZATION TO RELEASE INFORMATION

I authorize release of my medical record information, pursuant to applicable federal and state laws, rules and regulations, to third party payers and other providers participating in my care, that agree to treat my information in a confidential manner in accordance with all applicable federal, state, and local laws.

ASSIGNMENT OF BENEFITS

I hereby request that payment of authorized dental benefits be made on my behalf to Finley & Runyan, LLP for any services provided to me and/or my dependents. I authorize any holder of medical information about me and/or my dependents be released to the appropriate entity and its agents any information needed to determine these benefits payable for related services.

GUARANTEE OF PAYMENT

I understand payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable coinsurance and co-payments for insurance companies. Finley & Runyan, LLP accepts cash, personal checks, VISA, MasterCard, and Discover. There is a service charge for returned checks. In the event that I default on payment of my account, I understand I am responsible for any and all cost incurred on the collection of my account. If the debt is assigned to a third party collection agency, I agree to be responsible for collection fees and interest due to amounts in default.

WRITTEN ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I hereby acknowledge that I have received and had an opportunity to ask questions concerning the Notice of Privacy Practices of Finley & Runyan, LLP.

______________________________ ______________________
Patient Signature Date

______________________________ ______________________
Responsible Party Relationship to patient

RELEASE OF INFORMATION TO FAMILY OR FRIEND

I hereby authorize the following individuals to access my Protected Health Information. I understand that I may change this list by contacting Finley & Runyan, LLP.

1. ______________________________ 3. ______________________________

2. ______________________________ 4. ______________________________