Massa DENTISTRY

Patient Registration Today's Date _____

Patient Name _____ Driver's License _____

How did you hear about Massa Dentistry? _____

Is this visit related to a Routine Exam & Cleaning? Y ❒ N ❒ Is this an Emergency Dental Visit? Y ❒ N ❒

Address _____City _____ State _____ Zip _____

Phone: Home _____ Work _____ Cell _____

Date of Birth _____ SSN _____ Gender: M ❒ F ❒

Marital Status _____ Employer _____ Student: Y ❒ N ❒

Email Address _____ Contact via email: Y ❒ N ❒

Emergency Contact _____ Relationship _____ Phone _____

Responsible Party (if not the Patient) _____ *Phone* _____

*Relationship to patient: Spouse ❒Parent ❒ Legal Guardian ❒Other ❒*_____

Address _____*City* _____ *State* _____ *Zip* _____

Date of Birth _____ *SSN* _____ *Gender: M ❒ F ❒*

Marital Status _____ *Employer* _____ *Student: Y ❒N ❒*

Email Address _____ *Contact via email: Y ❒N ❒*

Name of Insured _____ Date of Birth _____

Name of Insurance _____ Group Number _____

Employer Name _____ Policy ID Number _____

Insurance Billing Address _____ Telephone _____

Relationship to patient: Self ❒ Spouse ❒Child ❒Other ❒ *Please fill out the rest if insured is not the patient*

Address _____*City* _____ *State* _____ *Zip* _____

Phone: Home _____ *Work* _____ *Cell* _____

SSN _____ *Gender: M ❒ F ❒* *Secondary Insurance: Y ❒N ❒*

Email Address _____ *Contact via email: Y ❒N ❒*

Massa DENTISTRY

Medical History

Patient Name _____ Date of Birth _____

Are you under a physician care now? Y ❒ N ❒ If yes, please explain _____
Have you been hospitalized or had major operation? Y ❒ N ❒ If yes, please explain _____
Have you had serious head and neck injury? Y ❒ N ❒ If yes, please explain _____
Have you taken Phen-Phen or Redux? Y ❒ N ❒ If yes, please explain _____
Have you taken Fosamax, Boniva, Actonel or any medication containing Bisphosphonates?
Y ❒ N ❒ If yes, please explain _____
Are you taking any medication or pills? Y ❒ N ❒ If yes, please explain _____
Are you on a special diet? Y ❒ N ❒ _____
Do you smoke or use tobacco? Y ❒ N ❒ _____
Do you use controlled substance? Y ❒ N ❒ _____

Women: Are you
Pregnant/Trying to get pregnant? Y ❒ N ❒ Nursing? Y ❒ N ❒ Taking Oral Contraceptives? Y ❒ N ❒

Are you allergic to the following: Aspirin ❒ Penicillin ❒ Codeine ❒ Local Anesthetic ❒
Acrylic ❒ Metal ❒ Latex ❒ Sulfa ❒ Other ❒ _____

Have you ever been told you needed to pre-medicate or take special precautions prior to dental treatment? Y ❒ N ❒
If yes, please explain _____

AIDS/HIV Positive	Y ❒ N ❒	Cortisone Medicine	Y ❒ N ❒	Hemophilia	Y ❒ N ❒	Radiation Treatments	Y ❒ N ❒
Alzheimer's Disease	Y ❒ N ❒	Diabetes	Y ❒ N ❒	Hepatitis A	Y ❒ N ❒	Recent Weight Loss	Y ❒ N ❒
Anaphylaxis	Y ❒ N ❒	Drug Addiction	Y ❒ N ❒	Hepatitis B or C	Y ❒ N ❒	Renal Dialysis	Y ❒ N ❒
Anemia	Y ❒ N ❒	Easily Winded	Y ❒ N ❒	Herpes	Y ❒ N ❒	Rheumatic Fever	Y ❒ N ❒
Angina	Y ❒ N ❒	Emphysema	Y ❒ N ❒	High Blood Pressure	Y ❒ N ❒	Rheumatism	Y ❒ N ❒
Arthritis/Gout	Y ❒ N ❒	Epilepsy or Seizures	Y ❒ N ❒	High Cholesterol	Y ❒ N ❒	Scarlet Fever	Y ❒ N ❒
Artificial Heart Valve	Y ❒ N ❒	Excessive Bleeding	Y ❒ N ❒	Hives or Rash	Y ❒ N ❒	Shingles	Y ❒ N ❒
Artificial Join	Y ❒ N ❒	Excessive Thirst	Y ❒ N ❒	Hypoglycemia	Y ❒ N ❒	Sickle Cell Disease	Y ❒ N ❒
Asthma	Y ❒ N ❒	Fainting Spells/Dizziness	Y ❒ N ❒	Irregular Heartbeat	Y ❒ N ❒	Sinus Trouble	Y ❒ N ❒
Blood Disease	Y ❒ N ❒	Frequent Cough	Y ❒ N ❒	Kidney Problems	Y ❒ N ❒	Spina Bifida	Y ❒ N ❒
Blood Transfusion	Y ❒ N ❒	Frequent Diarrhea	Y ❒ N ❒	Leukemia	Y ❒ N ❒	Stomach/Intestinal Dis.	Y ❒ N ❒
Breathing Problem	Y ❒ N ❒	Frequent Headaches	Y ❒ N ❒	Liver Disease	Y ❒ N ❒	Stroke	Y ❒ N ❒
Bruise Easily	Y ❒ N ❒	Genital Herpes	Y ❒ N ❒	Low Blood Pressure	Y ❒ N ❒	Swelling of Limbs	Y ❒ N ❒
Cancer	Y ❒ N ❒	Glaucoma	Y ❒ N ❒	Lung Disease	Y ❒ N ❒	Thyroid Disease	Y ❒ N ❒
Chemotherapy	Y ❒ N ❒	Hay Fever	Y ❒ N ❒	Mitral Valve Prolapse	Y ❒ N ❒	Tonsillitis	Y ❒ N ❒
Chest Pains	Y ❒ N ❒	Heart Attack/Failure	Y ❒ N ❒	Osteoporosis	Y ❒ N ❒	Tuberculosis	Y ❒ N ❒
Cold Sores/Fever Blisters	Y ❒ N ❒	Heart Murmur	Y ❒ N ❒	Pain in Jaw Joints	Y ❒ N ❒	Tumors or Growths	Y ❒ N ❒
Congenital Heart Disease	Y ❒ N ❒	Heart Pacemaker	Y ❒ N ❒	Parathyroid Disease	Y ❒ N ❒	Ulcers	Y ❒ N ❒
Convulsions	Y ❒ N ❒	Heart Trouble/Disease	Y ❒ N ❒	Psychiatric Care	Y ❒ N ❒	Venereal Disease	Y ❒ N ❒
						Yellow Jaundice	Y ❒ N ❒

Have you ever had any serious illness not listed above? Y ❒ N ❒
If yes, please explain _____
Comments: _____
_____
_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

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.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ **DATE** _____

181 Town Center Blvd. Suite 100, Jarrell TX 76537 | Telephone 512-746-5222
www.MassaDentistry.com

Massa DENTISTRY

Office Financial and Insurance Billing Policy

We look forward to providing you excellent dental care!

Our office remains dedicated to providing optimal care for every patient and working with you to achieve that goal. We pride ourselves in helping you in any way and in continuing to pride the quality of care to which you have become accustomed.

This is intended to provide you with information relative to our office's policies and procedures. We understand that patients have questions and concerns and hope to answer many of them on the following pages. Please read through this form as it should be helpful in preparing you for your upcoming appointment. If after reading this you have unanswered questions, please feel free to give our office a call.

Please let us know if you have any questions ... It will be our pleasure to help you.

If you have dental insurance, in order to better serve you, we ask that you familiarize yourself with your dental benefits. Dental treatment is based on your oral health needs, not on the type or amount of dental insurance you may have. Dental insurance is a benefit provided to you by your employer to help offset the cost of your dental treatment, alternatively, some patients pay for their dental insurance on their own. The benefits you receive under the terms of the contract have been negotiated by the insurance company and your employer, and not by our office.

What we do to help: we will use all of our resources to get as accurate an estimate as possible for your treatment. We will inform you of your estimated share for the payment, as a courtesy to you, we will also compute and submit your dental insurance for you. Because the insurance reimbursement process is often very complicated, please understand that we may need to request your assistance in certain case to help us process your claim.

Our office will do everything we can to help you maximize your insurance benefits. Unfortunately, due to the nature of the dental insurance industry, *there is no guarantee of payment.* Please understand that in the event your dental insurance company fails to pay for your treatment, you are responsible for all fees. If the insurance pay less than the estimate, we will bill you for the balance. If we are paid more than our estimate, we will credit back to your account what you overpaid.

Why? There is no regulation as to how insurance companies determine reimbursement levels, resulting in wide fluctuation. In addition insurance companies are not required to disclose how they determine these levels. The language used in this process may be inconsistent among carriers and difficult to understand. The reimbursement mechanism from your dental insurance company is merely a mathematical formula as to which benefits you will receive and the percentage of the dental office fee will be paid. We do not want to compromise your care based on restraints place by the insurance. Your dentist or the financial manager of the dental office may also be able to help explain dental plan issues to you. However, your dentist may not be able to answer specific questions about your dental plan or predict what your level of coverage for a procedure will be. Insurance companies provide us only with estimates, because plans offered by the same employer or written by the same third party payer can vary according to the contracts involved.

Massa DENTISTRY

Acknowledgement of Receipt and Review of Office Financial/Insurance Policy

1. I understand that payment in full is expected at each appointment. For your convenience, we offer the following methods of payment. Please check the option which you prefer.
   - ❒ Cash or Personal Check
   - ❒ ❒ Credit Card ❒ Visa ❒ MasterCard ❒ Discover ❒ American Express
   - ❒ ❒Care Credit
   - ❒ If you have any questions on payment options, it will be our pleasure to assist you.

2. I understand that the full responsibility for payment of all fees for dental services provided in this office for me or my dependents is mine, due and payable at the time services are rendered, regardless of insurance coverage.

3. I understand that it is imperative that I am aware of my insurance policy coverage, and it is my responsibility to inform your office should there be any changes in my policy.

4. I understand that despite verifications of eligibility & benefits made by this office; prior to my appointment, ***insurance company never guarantee payment*** for services rendered. If my insurance carrier does not pay or pay less than my actual bill, I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

5. **I authorize and hereby request my insurance company to pay directly to the dentist, Lourdes R. Massa DDS DMD, Massa Dentistry, insurance benefits otherwise payable to me, for services rendered to me or my dependents _____.**

6. In the event of default, I will be charged for a $25.00 Returned Check Fee for insufficient funds, reasonable attorney's fee and collection cost. I further understand that a monthly billing charge of $5.00 will be added to any balance over 30 days.

7. I understand that when I schedule an appointment, the time is reserved exclusively for me and that there will be a charge of $50.00 for the first (1st) hour appointment failed or rescheduled without 48 hours' notice or $25.00 for every additional half (1/2) hour increment missed and for late appointment.

8. I authorize Massa Dentistry to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payers and/or health practitioners, to the extent permitted under applicable law.

I, the undersigned, certify that I have read and fully understand the above agreement.

Name & Signature of Responsible Party _____Date _____

Patient Name _____Date of Birth_____ Witness Signature _____

Massa DENTISTRY

Dental Treatment Consent

Patient Name _____ Date of Birth _____

I HEREBY AUTHORIZE THE FOLLOWING PROCEDURE(S) TO BE PERFORMED UPON ME OR THE NAMED PATIENT:
(attach treatment plan)

_____

_____

1. THE PURPOSE OF THE PROCEDURE(S) HAS BEEN FULLY EXPLAINED TO ME AND HAS ALSO INFORMED ME OF EXPECTED BENEFITS AND COMPLICATIONS (FROM KNOWN AND UNKNOWN CAUSES), ATTENDANT DISCOMFORTS AND RISKS THAT MAY ARISE, AS WELL AS POSSIBLE ALTERNATIVES TO THE PROPOSED TREATMENT, INCLUDING NO TREATMENT. THE ATTENDANT RISKS OF NO TREATMENT HAVE ALSO BEEN DISCUSSED. I HAVE BEEN GIVEN AN OPPORTUNITY TO ASK QUESTIONS, AND ALL MY QUESTIONS HAVE BEEN ANSWERED FULLY AND SATISFACTORILY. I ACKNOWLEDGE THAT NO GUARANTEES OR ASSURANCES HAVE BEEN MADE TO ME CONCERNING THE RESULTS INTENDED FROM THE PROCEDURE(S).

2. I, THE UNDERSIGNED, HEREBY AUTHORIZE TO TAKE X-RAYS, STUDY MODELS, PHOTOGRAPHS, OR ANY DIAGNOSTIC AIDS DEEMED APPROPRIATE BY THE DENTIST TO MAKE A THOROUGH DIAGNOSIS OF MY DENTAL NEEDS.

3. **DRUGS AND MEDICATION:** I UNDERSTAND THAT ANTIBIOTICS AND ANALGESICS AND OTHER MEDICATIONS CAN CAUSE ALLERGIC REACTIONS CAUSING REDNESS AND SWELLING OF TISSUES, PAIN, ITCHING, VOMITING, AND/ OR ANAPHYLACTIC SHOCK (SEVERE ALLERGIC REACTION).

4. **ANESTHESIA:** I REALIZE THE RISKS IN RECEIVING AN ANESTHETIC, SOME OF WHICH ARE UPSET STOMACH, DIZZINESS, AND VOMITING, ADVERSE REACTION TO DRUGS CAUSING CARDIAC ARREST, MISCARRIAGE.

5. **CHANGES IN TREATMENT PLAN** I UNDERSTAND THAT DURING THE COURSE OF THE PROCEDURE(S), UNFORESEEN CONDITIONS MAY ARISE WHICH NECESSITATE PROCEDURES DIFFERENT FROM THOSE CONTEMPLATED. I UNDERSTAND THAT DURING TREATMENT IT MAY BE NECESSARY TO CHANGE OR ADD PROCEDURES BECAUSE OF CONDITIONS FOUND WHILE WORKING ON THE TEETH THAT WERE NOT DISCOVERED DURING EXAMINATION, THE MOST COMMON BEING ROOT CANAL THERAPY FOLLOWING ROUTINE RESTORATIVE PROCEDURES. I, THEREFORE CONSENT TO THE PERFORMANCE OF ANY/ALL CHANGES AND ADDITIONAL PROCEDURE(S) WHICH THE ABOVE NAMED DENTIST OR HER ASSOCIATES MAY CONSIDER NECESSARY.

I UNDERSTAND THAT DENTISTRY IS NOT AN EXACT SCIENCE AND THAT, THEREFORE, REPUTABLE PRACTITIONERS CANNOT FULLY GUARANTEE RESULTS. I ACKNOWLEDGE THAT NO GUARANTEE OR ASSURANCE HAS BEEN MADE BY ANYONE REGARDING THE DENTAL TREATMENT, WHICH I HAVE REQUESTED AND AUTHORIZED. I HAVE HAD THE OPPORTUNITY TO READ THIS FORM AND ASK QUESTIONS. MY QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION.

I UNDERSTAND THE FINANCIAL OBLIGATION ATTACHED TO THIS PROCEDURE AND AGREE TO COMPLY AS LISTED ON A SEPARATE SERVICE AGREEMENT, WHERE I UNDERSTAND AND ACKNOWLEDGE THAT I AM FINANCIALLY RESPONSIBLE FOR ALL FEES FOR THE SERVICES PROVIDED FOR MYSELF OR THE ABOVE NAMED, REGARDLESS OF INSURANCE COVERAGE.

I, THE UNDERSIGNED, CONSENT TO THE PROPOSED TREATMENT AND CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT AND THAT ALL BLANK SPACES HAVE BEEN COMPLETED PRIOR TO MY SIGNING.

_____	_____	_____	_____
NAME OF RESPONSIBLE PARTY	**SIGNATURE OF RESPONSIBLE PARTY**	**RELATIONSHIP**	**DATE**

_____	_____	_____	_____
INTERPRETER (IF USED)	**DATE**	**SIGNATURE OF WITNESS**	**DATE**

THIS IS TO CERTIFY THAT DR. LOURDES MASSA EXPLAINS THE NATURE, PURPOSE, BENEFITS, RISKS OF, AND ALTERNATIVES (INCLUDING NO TREATMENT AND ATTENDANT RISK(S), TO THE PROPOSED PROCEDURE(S). DR. MASSA OFFERED ANSWERS TO ANY QUESTIONS AND FULLY ANSWER SUCH QUESTIONS AND BELIEVES THAT THE PATIENT/PARENT/GUARDIAN FULLY UNDERSTANDS WHAT WAS EXPLAINED AND ANSWERED.

Massa DENTISTRY

HIPAA Acknowledgement & Consent for Use and Disclosure of Health Information

Patient Name _____ Date of Birth _____

Please put Initials on the following:

_____ **Notice of Privacy Practices**
I acknowledge that I have received the practice's Notice of Privacy Practices which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment activities, healthcare operations and other described and permitted uses and disclosures. I understand that I may contact the Privacy Officer designated on the Notice if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my protected health information for the purposes described in the practices Notice of Privacy Practices.

_____ **Release of Information**
I hereby permit Massa Dentistry practice, other dental or medical health professionals and insurance companies involved in my dental care to release healthcare information for purposes of care decisions, treatment, payment, or healthcare operations.

Disclosures to Friends and/or Family Members
I give permission for my protected health Information to be disclosed for purpose of communicating diagnosis, treatment and care decisions to the family members and other listed below:

Name _____ *Relationship* _____ *Phone* _____
Name _____ *Relationship* _____ *Phone* _____

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice through our website www.MassaDentistry.com

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent-

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

Consent to Email or Text Usage for Appointment Reminders

Massa DENTISTRY

& Other Healthcare Communications

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information.

If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communication/information at that email or text address from the practice.

_____(Patient initials) I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing (see revocation section below). The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

The email that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information is _____.

The cell phone number that I authorize to receive text messages for appointment reminders and general health reminders/feedback/information is _____.

_____(Patient initials) I consent to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for education purpose, security purposes and/or the practice's health care operations purposes (e.g., quality improvement activities).

I understand that the practice retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used without a specific written authorization from me or my legal representative unless it is for treatment, education, payment or health care operations purposes or otherwise permitted or required by law.

Revocation

I hereby revoke my request for future communications via email and/or text.
_____I hereby revoke my request to receive any future appointment reminders, feedback, and general health via text messages.
_____I hereby revoke my request to receive any future appointment reminders, feedback, and general health via email.

NOTE: This revocation only applies to communications from this Practice.
Patient Name _____ Date _____
Patient/Patient Representative Signature: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ❒ Individual refused to sign
- ❒ Communications barriers prohibited obtaining the acknowledgement
- ❒ An emergency situation prevented us from obtaining acknowledgement
- ❒ Other (Please Specify) _____