Patient I.D. # _____

Date _____ (Mo Day Yr)

PATIENT REGISTRATION WELCOME TO OUR OFFICE *ALL INFORMATION IS CONFIDENTIAL*

The following information is required by the dentist to assist in proper diagnosis and treatment.
Please feel free to ask the receptionist for help in completion this form. PLEASE PRINT.

ADULT Patient or PARENT/GUARDIAN Registration SSN: _____

Are you the: ☐ PATIENT ☐ PARENT ☐ GUARDIAN

Name: _____ (last) (first) (initial) Driver's Lic. No.: _____

Address: _____ (street) (city) (state) (zip code)

Date of Birth: _____ (Mo. Day Yr.) Age ___ Sex ___ Marital Status _____ Home Phone: ( ) _____

Cell phone #: _____ E-Mail address: _____

Patient's Previous Dentist: _____ Phone: ( ) _____

Patient's Family Physician: _____ Phone: ( ) _____

Patient's Medical Specialist: _____ Phone: ( ) _____
(if under present care)

CHILD Registration or ADULT Under Guardianship SSN: _____

Name: _____ (last) (first) (initial) **Prefers to be called:** _____

Address: _____ (if different than above) (street) (city) (state) (zip code)

Date of Birth: _____ (Mo. Day Yr.) Age ___ Sex ___ Home Phone: ( ) _____

School/College _____ (city) (state)

Person Responsible for account: Relationship to patient: _____

Name: _____ Home Phone: ( ) _____

Address: _____ (street) (city) (state) (zip code)

Employed by: _____ Phone: ( ) _____

Do you prefer to receive calls at: ☐ Work ☐ Home ☐ Either

Occupation: _____ SSN: _____

Spouse employed by: _____ Phone: ( ) _____

Dental Insurance: ☐ Yes ☐ No Name of Insured: _____

Date of Birth: _____ (Mo. Day Yr.) SSN: _____ Relationship to Patient: _____

Insurance Co. Name: _____ Group Policy No.: _____ Cert. No.: _____

Percentage of coverage: Basic ____ % Prosthetics ____ % Crown/Bridge ____ % Ortho ____ %

Secondary Insurance: ☐ Yes ☐ No Name of Insured: _____

Date of Birth: _____ (Mo. Day Yr.) SSN: _____ Relationship to Patient: _____

Insurance Co. Name: _____ Group Policy No.: _____ Cert. No.: _____

Percentage of coverage: Basic ____ % Prosthetics ____ % Crown/Bridge ____ % Ortho ____ %

In case of emergency: _____ Phone: ( ) _____

Closest Family Relative: _____ Phone: ( ) _____

Whom may we thank for referring you? _____

Is another family member or relative a patient at our office? _____

MEDICAL HISTORY Date _____ (Mo Day Yr)

MEDIC ALERT	

The following information is required by the dentist to assist in proper diagnosis and treatment. *ALL INFORMATION IS CONFIDENTIAL*

CIRCLE

1. Have you had an illness requiring hospitalization or extensive care? ..... YES NO
   Specify: _____
2. Are you presently under the care of a physician? ..... YES NO
   Explain: _____
3. Has your present health changed in the previous year? ..... YES NO
   Explain: _____
4. Have you been hospitalized in the last 5 years? ..... YES NO
   Specify: _____
5. Do you use any prescription or non-prescription medicine regularly? ..... YES NO
   Specify: _____
6. Do you have any allergic condition: i.e. asthma, hay fever, skin rash, food allergies? ..... YES NO
7. Do these allergic reactions result in headache, shortness of breath, chest constriction, or nausea? ..... YES NO
   Specify: _____
8. Have you ever experienced any unusual reaction to any of the following? (please circle) YES NO
   local anesthesia (freezing), aspirin, penicillin, iodine, sulfonamide (sulfa), barbiturates (sleeping pills), or any other medicine? Explain: _____
9. Have you been warned against taking any drug or medication? ..... YES NO
10. Do you have or have you ever had any of the following? (please circle) ..... YES NO

heart murmur or other heart condition	hyper/hypoglycemia	venereal disease	diabetes	HIV infection	fainting spells
stomach/intestinal problems	epilepsy or seizures	any lung disease	tuberculosis	herpes	osteoporosis
joint replacement (hip, knee)	arthritis or rheumatism	thyroid disease	stroke	kidney disease	_____
mental or nervous disorder	scarlet or rheumatic fever	AIDS	cancer	sinus trouble	sleep apnea
high/low blood pressure	hepatitis A or B or C	jaundice	heart attack	liver disease	

11. Do you have any disease, condition or problem not listed above that you think the doctor should know about? YES NO
    Explain: _____
12. Have you ever had any known contact with the AIDS/HIV virus? ..... YES NO
13. Have you been diagnosed with HPV (Human Papillomavirus) ..... YES NO
14. Are you taking blood thinners ..... YES NO
15. Are you taking bisphosphonates or aspirin ..... YES NO
16. Has any member of your family had diabetes? ..... YES NO
17. Do you bruise easily or bleed abnormally? ..... YES NO
18. Have you had any weight changes in the last year? ..... YES NO
    Current weight _____ lbs., lost or gained in the last year +_____ lbs. - _____ lbs. .....
19. Do you have any bleed disorders such as anemia or thalassemia (major, minor)? ..... YES NO
20. Have you ever had radiation treatment or chemotherapy? ..... YES NO
    Explain: _____
21. Have you ever had any injury, surgery or x-ray therapy to your face or jaws? ..... YES NO
22. Do you have frequent severe headaches? ..... YES NO
23. Do you have frequent earaches, ear/throat infections or any hearing difficulty? ..... YES NO
24. Is your eyesight: ..... ☐ good ☐ adequate ☐ poor
25. Have you had swollen lymph glands, thyroid or parathyroid problems, excessive thirst, frequent urination, or any recurrent illness? ..... YES NO
    Explain: _____
26. Do you ever experience shortness of breath or pain in your chest when walking or climbing stairs? ..... YES NO
27. Have you had any organ transplants or medical implants? ..... YES NO
28. Are you wearing the transdermal nicotine patch? ..... YES NO
29. In past & present years have you smoked or used any other forms of tobacco? ..... YES NO
30. WOMEN -Are you pregnant? _____ months ..... YES NO
    -Nursing? ..... YES NO
    -Are you taking birth control pills? ..... YES NO

TO AVOID COMPLICATIONS, NOTIFY OUR OFFICE OF ANY CHANGES IN YOUR MEDICAL CONDITION

DENTAL HISTORY **Date** _____ (Mo Day Yr)

MEDIC ALERT	

1. How frequently do you see your dentist? ☐ 6 months ☐ yearly ☐ other _____
   Last dental visit _____ Last cleaning _____ Last full mouth series of x-rays _____
2. Rate your current dental health as: ☐ good ☐ fair ☐ poor Is your sugar intake: ☐ high ☐ medium ☐ low
3. Brushing: ☐ vigorous ☐ light How often? _____
4. Cleaning aids presently used: ☐ floss ☐ stimudents ☐ toothpick ☐ other _____ CIRCLE
5. Is there a dental problem you would like to have taken care of as soon as possible?..... YES NO
   Explain: _____
6. Have you been given oral hygiene instruction in: ☐ brushing ☐ flossing ☐ other _____ YES NO
7. Does food tend to get caught between your teeth?..... YES NO
8. Are your teeth sensitive to: ☐ cold ☐ sweets ☐ heat ☐ pressure ☐ other _____ YES NO
9. Do your gums bleed when: ☐ brushing ☐ flossing ☐ spontaneously ☐ eating/chewing..... YES NO
10. Have you ever had any of the following? (please circle)..... YES NO
    oral surgery, periodontal treatment, orthodontic treatment, bite adjustment, bite plate or other appliance. YES NO
    Specify: _____
11. Do you have any dental implants? ..... YES NO
12. Do you suffer from pain and/or swelling of your gums?..... YES NO
13. Are you aware of any loose teeth? Where? _____ YES NO
14. Do you chew on only one side of your mouth? Why? _____ YES NO
15. Habits, do you
    - grind or clench your teeth during the day or night?..... YES NO
    - mouth breathe while awake or asleep?..... YES NO
    - bite your lips or cheeks regularly?..... YES NO
    - hold any foreign objects with your teeth? (i.e. pipe, pencils, nails)..... YES NO
16. Does any part of your mouth hurt when clenched?..... YES NO
17. Does your jaw crack or pop when opened widely?..... YES NO
18. Do you have any difficulty in opening or closing your jaw?..... YES NO
19. Do you have any pain in your ears?..... YES NO
20. Do you gag easily?..... YES NO
21. Have you experienced any growth or sore spots in your mouth?..... YES NO
    Where? _____
22. Are you concerned about the appearance of your teeth?..... YES NO
    What would you like to change? _____
23. Do you have any concerns regarding your dental visit? ☐ fear ☐ pain ☐ time ☐ money
    ☐ embarrassment ☐ other Explain: _____

AUTHORIZATION, RELEASE and AGREEMENT to pay for Services Rendered

I, the undersigned, certify that all of the medical and dental information provided is true to the best of my knowledge, and I have not knowingly omitted any information.
I authorize the dentist 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 other health practitioners.
I authorize and hereby request my insurance company to pay directly to the dentist (or the dental group) insurance benefits otherwise payable to me.
I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents or charges.

X _____ Date _____ _____
Signature of patient, parent if minor or guardian of adult under guardianship (Mo. Day Yr.) Please print name also

CONSENT for TREATMENT

I, the undersigned, consent to the performing of the dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anesthetic as indicated, and will assume responsibility for fees associated with these procedures.

X _____ Date _____ _____
Signature of patient, parent if minor or guardian of adult under guardianship (Mo. Day Yr.) Please print name also

MEDICAL HISTORY UPDATE — if change, record in medical history

Mo. Day Yr.	Same	Change	Patient Signature	Dr. Initials
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		

Mo. Day Yr.	Same	Change	Patient Signature	Dr. Initials
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		

MEDICAL HISTORY - DENTAL HISTORY

Date _____

Patient Name _____

Are you taking any Bisphosphonates? ____ Yes ____ No

If yes, how long have you been taking them? _____

Group 1: **Fosamax, Actonel, Boniva, Forteo, Reclast IV** or any other related oral bone supporting medication (Circle one of the above or indicate other): _____

Group 2: Have you ever been treated for breast cancer or prostate cancer?
____ Yes ____ No

As part of the treatment, did you receive IV forms of Bisphosphonates like **Aredia** or **Zometa** (Circle One)

If so, when did you receive the IV treatment? _____

_____ _____

Signature of Patient Witness

DAVID M. RIZK, DDS

7211 N. MESA
#1 NORTH
EL PASO, TX 79912

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Protecting Your Confidential Health Information is Important to Us

Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully

Our Promise!

Dear Patient:

This is not meant to alarm you! Quite the opposite! It is our desire to communicate to you that we are taking the new Federal (HIPAA - Health Insurance Portability and Accountability Act) laws written to protect the confidentiality of your health information seriously. We do not ever want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside of our office.

So what has changed? Why a privacy policy now? Very good questions!

The most significant variable that has motivated the Federal government to legally enforce the importance of the privacy of health information is the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the Internet, phone, faxes, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we use to ensure the protection of your health information everywhere it is used.

We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights as our valuable patient.

We will use and communicate your HEALTH INFORMATION only for the purposes of providing your treatment obtaining payment and conducting health care operations. Your health information will not be used for other purposes unless we have asked for and bee voluntarily given your written permission

How your HEALTH INFORMATION may be used

To Provide Treatment

We will use your HEALTH INFORMATION within our office to provide you with the best health care possible. This may include administrative and clinical office procedures designed to optimize scheduling and business office staff. In addition we may share your health information with referring physicians, clinical and pathology laboratories, pharmacies or other health care personnel providing you treatment.

To Obtain Payment

We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

To Conduct Health Care Operations

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.

In Patient Reminders

Because we believe regular care is very important to your general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be interest to you or your family.

These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best preventive and curative care modern medicine can provide. They may include postcards, folding postcards, letters, telephone reminders or electronic reminders such as email (unless you tell us that you do not want to receive these reminders).

Abuse or Neglect

We will notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law or with the patient's agreement.

Public Health and National Security

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

For Law Enforcement

As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

Family, Friends and Caregivers

We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want we will use our very best judgment when sharing your health information only when it will be important to those participating in providing your care.

To Coroners, Funeral Director and Medical Examiners

We may be required by law to provide information to coroners, funeral directors and medical examiners for the purposes of determining a cause of death and preparing for a funeral.

Medical Research

Advancing medical knowledge often involves learning from the careful study of the medical histories of prior patients. Formal review and study of health histories as a part of a research study will happen only under the ethical guidance, requirements and approval of an Institutional Review Board.

Authorization to Use or Disclose Health Information

Other than is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

Patient Acknowledgment

Patient Name(s): _____

_____

_____

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not we would appreciate very much your acknowledging your receipt of our policy by signing and returning this card. We look forward to seeing you again soon!

_____

Patient Signature

Date _____ /_____ / _____

Patient Rights

This new law is careful to describe that you have the following rights related to your health information.

Restrictions

You have the right to request restrictions on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable restriction preferences from our patients.

Confidential Communications

You have the right to request that we communicate with you in a certain way. You may request that we only communicate your health information privately with no other family members present or through mailed communications that are sealed. We will make every effort to honor your reasonable requests for confidential communications.

Inspect and Copy Your Health Information

You have the right to read, review, and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

Amend Your Health Information

You have the right to ask us to update or modify your records if you believe your health information regards are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information In order to standardize our process, please provide us with your request in writing and describe your reason for the change.

Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete.

Documentation of Health Information

You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health operation. Our documentation procedures will enable us to provide information on health information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a times. We may need to charge you a reasonable fee for your request.

Request a Paper Copy of this Notice

You have the right to obtain a copy of this Notice of Privacy Practices directly from our office a any time. Stop by or give us a call and we will mail or email a copy to you.

We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve th right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised Notice.

You have the right to express complaints to us or to the secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. Please let us know of your concerns or complaints in writing.

WRITTEN FINANCIAL POLICY

Thank you for choosing **Dr. David M. Rizk**. Our primary mission is to deliver the best dental care available. An important part of the mission is making the cost of optimal care easy and manageable for our patients as possible by offering several payment options.

Dr. David M. Rizk requires payment at time of service.

Payment Options:

You can choose from: Cash, Check, Visa, MasterCard, American Express, or Discover Card.
Convenient monthly payment plans from *Care Credit.
Any additional financial arrangements will need to be made with Dr. David M. Rizk.

Please be familiar with your individual insurance requirements and coverage.

For patients with "in-network" dental insurance we are happy to work with your insurance carrier to maximize your benefit, upon receipt of a written pre-determination of your benefits and payment in full of your estimated portion for treatment, we will accept assignment for the estimated balance due. However, if we do not receive payment from your insurance within 60 days you will be responsible for payment of treatment fees and collection of your benefits directly from your carrier.

For patients with "out of network" dental insurance we will collect assignment in full when services are preformed and gladly file to your insurance company so that you are reimbursed. If you do not hear from your insurance in 3 weeks after procedure, Please do not hesitate to call us so we can re-file another insurance claim or touch base with your insurance.

To file insurance please provide us with an insurance document and identification. Insurance document must have name of insurance company, telephone number a group policy number and your I.D. number.

If you have any questions please do not hesitate to ask, we are here to help get the dentistry you need and want.

_____ _____

Patient, Parent or Guardian Date