LIFESMILES
by
RANDY MITCHMORE, DDS

PATIENT REGISTRATION

PATIENT INFORMATION

Name _____ Birthdate _____ Age _____
(Last) (First) (Preferred) (MI)

Social Security No. _____ Driver's License No. _____

Address _____

City _____ State _____ Zip _____

Email Address _____

Home Phone _____ Work Phone _____ (Ext) Cell Phone _____

- May We Contact You By Email? Yes ☐ No ☐
- May We Contact You By Cell? Yes ☐ No ☐

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

EMPLOYMENT

Employer _____

Business Address _____

City _____ State _____ Zip _____

Your Occupation _____

EMERGENCY

Who should we contact in an emergency?

Name _____

Home Phone _____ Cell Phone _____

Relationship _____ [Husband, Wife, Life Partner, Significant Other, Best Friend, Soulmate...]

P: (713) 592-9300 | F: (713) 592-8111 | Web: lifesmiles.us | 1722 W Alabama Street | Houston, TX 77098
Master, Academy of General Dentistry | Master, American Dental Implant Association

Dental Insurance

Primary Carrier

Insurance Company _____

Address _____

Person Insured _____

ID Subscriber No. _____

Group No. _____

Secondary Carrier

Insurance Company _____

Address _____

Person Insured _____

ID Subscriber No. _____

Group No. _____

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Medical History

Section I

Are you having any pain or discomfort at this time? Yes ☐ No ☐

Have you been under the care of a medical doctor during the last two years? Yes ☐ No ☐

** If yes, please state the reason:*

Are you allergic to, or have any reactions to medications? Yes ☐ No ☐

** If yes, please list:*

Section II

Have you taken any prescription medication or drugs of any kind within the last two years? Yes ☐ No ☐

Are you now taking any medications, pills, herbs, vitamins and or recreational drugs at this time? Yes ☐ No ☐

** If yes, please list:*

Have you ever been advised to be pre-medicated for any dental treatment?

** If yes, please state the reason:*

Indicate which of the following you have had or have at present:

Section III

Heart Disease/Attack	Yes ☐	No ☐	Diabetes	Yes ☐	No ☐
Angina/Heart Surgery	Yes ☐	No ☐	Hypoglycemia	Yes ☐	No ☐
High Blood Pressure	Yes ☐	No ☐	Thyroid Disease	Yes ☐	No ☐
Heart Murmur	Yes ☐	No ☐	Cancer/Chemotherapy	Yes ☐	No ☐
Pre-Medication	Yes ☐	No ☐	Arthritis/Rheumatism	Yes ☐	No ☐
Rheumatic Fever/Scarlet Fever	Yes ☐	No ☐	Glaucoma	Yes ☐	No ☐
Artificial Heart Valve/Pacemaker	Yes ☐	No ☐	A.I.D.S./H.I.V.	Yes ☐	No ☐
Stroke	Yes ☐	No ☐	Hepatitis A (infectious)	Yes ☐	No ☐
Artificial Joints (Hip/Knee/Etc)	Yes ☐	No ☐	C or B (Serum)	Yes ☐	No ☐
Kidney Trouble	Yes ☐	No ☐	Headaches	Yes ☐	No ☐
Lung Problems	Yes ☐	No ☐	Liver Disease	Yes ☐	No ☐
Emphysema	Yes ☐	No ☐	Sinus Trouble	Yes ☐	No ☐
Tuberculosis (TB)	Yes ☐	No ☐	Hemophilia	Yes ☐	No ☐
Asthma	Yes ☐	No ☐	Drug Addiction	Yes ☐	No ☐
Sexually Transmitted Disease	Yes ☐	No ☐	Sickle Cell Disease	Yes ☐	No ☐
Epilepsy/Seizures	Yes ☐	No ☐	Allergies/Hives	Yes ☐	No ☐

Section IV

Do you have any disease, condition or problem not listed? Yes ☐ No ☐

** If yes, please list/describe:*

Do you smoke or use other tobacco products? Yes ☐ No ☐

** If yes, how often*

Are you pregnant? Yes ☐ No ☐ If yes, what month?

Nursing? Yes ☐ No ☐ Birth control Pills? Yes ☐ No ☐

Approval

I understand all of the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Furthermore I hereby give Dr. Randy Mitchmore permission to use dental imagery taken during my visit for educational or promotional purposes.

Signature: _____

Print Name: _____ Date: / /

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Our Appointment Policy

We respectfully look forward to serving you and greatly appreciate the confidence you show in choosing us to be your dental office.

We are very respectful of your time. Scheduling and timely rendering of the services of your choice is an integral part of our practice.

We ask you for the same courtesy. We understand that there are times when an appointment reservation becomes inconvenient. When this occurs, we ask for a full 24 hour notice of your change.

Failure to come for a reserved appointment time without proper notification can result in a cancellation fee that will be applied to your account.

This fee can range from $25 on up depending upon the length of your reserved appointment time.

Signature (Patient or Responsible Party) _____ Date / /

Financial Responsibility Policy

I understand that responsibility for payment for my dental services provided by Dr. Mitchmore's office for myself, or my dependents, is mine and is due and must be paid upon the day the services are rendered unless financial arrangements have been made. I also understand that a 1.5% finance charge will be added to any balance over 60 days. In the event of default, I(We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Signature (Patient or Responsible Party) _____ Date / /

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Notice of Privacy Practices

- *This notice describes how your personal health information about you may be used or disclosed and how you can have access to this information. *Please review carefully.*

Description of specific information to be used or disclosed:
The exchange of pertinent dental x-rays, pictures, narratives of procedures and treatment plans to doctors of referral or insurance companies for the benefit of filing dental claims for the individual named on this form.

Person or entity requesting the information:
Dr. Randy Mitchmore and his administrative team will distribute such specific information to persons or entities upon request, with the authorization from Dr. Randy Mitchmore, only to appropriate parties on a case by case basis.

Recipient of the information:
Doctors or insurance companies that Dr. Mitchmore deems necessary for the continuing care or financial benefit of the patient named on this form.

This information must be requested for the following purpose(s):
Continuing care, specialized treatment and or dental insurance claims.

This authorization shall remain in effect from the date signed until otherwise notified.

I UNDERSTAND THE FOLLOWING:

I may inspect or copy the protected health information to be used or disclosed.
I may request corrections to my information.
I may request my information be restricted.
I may request confidential communications.
I may request a report of disclosures of my information.
I may request a copy of this notice.

I have reviewed this office's Notice of Privacy Practices, which explains how my medical/dental information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

I have been given and read the **Notice of Privacy Practice Act** (HIPPA).

_____ _____ / / _____

Signature (Patient or Responsible Party) Date

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