Patient Registration Form

Patient Name: _____ Date of Birth: _____ SSN: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Additional Phone: _____

Email: _____

Employer: _____

Employer Address: _____ City: _____ State: ____ Zip Code: _____

Emergency Contact Name: _____ Phone Number: _____

Who can we thank for recommending:

___ Friend ___ Family ___ Member ___ Flyer ___ Other: _____

Insurance on record ___

Main Insurance	Secondary Insurance
Insurance name:	Insurance name:
Subscriber Name:	Subscriber Name:
Subscriber to Patient Relationship:	Subscriber to Patient Relationship:
Identification number:	Identification number:
Group number:	Group number:
Subscriber's Date of Birth:	Subscriber's Date of Birth:

We need the information above so that we can help you obtain the dental insurance benefits for which you are eligible. This may require submitting the doctor's treatment plan to the insurance company (s) for prior determination of benefits, or in some cases obtaining the information over the phone and online. We can NEVER guarantee payment from your insurance company. The insurance company contract is with you and your employer.

Politics and procedures

I understand and agree that, regardless of my insurance status, I am ultimately responsible for my account balance for professional services rendered. I certify that the information on the patient registration form is true and correct to the best of my knowledge. I will notify Lone Star Family Dental of any change in my health status or any change in the above information.

Patient / Guardian Signature: _____ Date: _____

Patient Information

Patient Name: _____ Preferred Name: _____ □ Male □Female

□Married □Single □Child DOB: _____ Address: _____ Home#: _____

Work: _____ Cell: _____ City: _____ State: _____

EMAIL: _____

MEDICAL HISTORY

Have you ever had any of the following? Please circle all those that apply:

Heart Disease:
- High Blood Pressure YES NO
- Heart Attack YES NO
- Heart Surgery YES NO
- Angina Pectoris YES NO
- Heart Murmur YES NO
- Artificial Valves YES NO
- Pacemaker YES NO
- Mitral Valve Prolapse YES NO

_____

_____

Respiratory Problems:
- Asthma YES NO
- Bronchitis YES NO
- Emphysema YES NO
- Pneumonia YES NO
- Tuberculosis YES NO
- Cough YES NO
- Hay Fever YES NO
- Sinus Problems YES NO
- Allergies YES NO

Kidney Disease: _____

_____

Blood Disease:
- Prolonged Bleeding YES NO
- Hemophilia YES NO
- Blood Transfusion YES NO
- Sickle Cells YES NO
- Anemia YES NO
- Bruise Easily YES NO

_____

_____

Liver Disease:
- Jaundice YES NO
- Hepatitis A, B, C YES NO

_____

_____

G.I Disease:
- Stomach Ulcers YES NO
- Acid Reflex YES NO

_____

Cancer: _____

_____

- Chemotherapy YES NO
- Radiation YES NO
- AIDS/HIV YES NO
- Artificial Joints YES NO
- Cortisone or Steroid Therapy YES NO
- Diabetes YES NO
- Thyroid Disease YES NO
- Venereal Disease YES NO
- Glaucoma YES NO
- Head Injuries YES NO
- Depression YES NO
- Epilepsy or Seizures YES NO
- Fainting/ Dizziness YES NO
- Mental Disorder YES NO
- Nervous Disorder YES NO
- Stroke YES NO
- Organ Transplant YES NO

_____

Allergic to:
- Sulfa Drugs YES NO
- Penicillin YES NO
- Codeine YES NO
- Metals YES NO
- Plastic, Rubber
- Latex YES NO

_____

_____

_____

WOMEN ONLY
- Pregnant YES NO
- Due Date: _____
- Oral Contraceptives? YES NO
- Other: _____

_____

Have you ever had any complications following treatment? □ YES □ NO

If yes, please explain: _____

_____

List all medication, Dose and Reason for taking:

Name:	Dose:	Reason:
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Signature: _____ Date: _____

Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

Lone Star Family Dental
3701 Shaver St
Pasadena Tx,77504

Acknowledgement

I, _____, hereby acknowledge that I have received and reviewed a copy of Lone Star Family Dental *HIPAA Notice of Privacy Practices*.

I understand that Lone Star Family Dental *HIPAA Notice of Privacy Practices* may change periodically and that I am entitled to receive a copy of Lone Star Family Dental revised *HIPAA Notice of Privacy Practices* upon request.

I understand that, if I have questions about Lone Star Family Dental *HIPAA Notice of Privacy Practices*, I may contact Tracie Bennett at (985) 290-3830.

I understand that it is my right to refuse to sign this Acknowledgement should I so choose, and that Lone Star Family Dental will not refuse treatment to me if I refuse to sign this Acknowledgement.

I further understand that I may contact the Secretary of the U.S. Department of Health and Human Services should I have concerns regarding Lone Star Family Dental privacy policies and procedures. For information on how to contact the U.S. Department of Health and Human Services, please ask Tracie Bennett, noted above, for assistance.

_____ Patient Signature	_____ Date
_____ Signature of Personal Representative	_____ Print Name of Personal Representative
	_____ Relationship of Personal Representative to Patient

FOR OFFICE USE ONLY

Lone Star Family Dental made a good-faith effort to obtain Acknowledgement, from the patient noted above, of receipt of its *HIPAA Notice of Privacy Practices*. In spite of these efforts, Lone Star Family Dental was unable to obtain a signed Acknowledgement for the following reason(s):

- ☐ Refusal to sign Acknowledgement on _____, 20_____.
- ☐ Communications barriers prohibited us from obtaining a signed Acknowledgement.
- ☐ An emergency situation prohibited us from obtaining a signed Acknowledgement.
- ☐ Other (Describe):_____

Date Received	By	Patient ID

Patient Information

ave you been admitted to a hospital or needed emergency care? Yes No
f yes, please explain: _____

Are you now under the care of a physician? Yes No
If yes, please explain: _____
Name of Physician: _____ Phone#: _____

Do you have any health problems that need further clarification? Yes No
If yes, please explain: _____

What is you weight? _____ What is your height? _____
Have you lost or gained over 10 pounds in the past year? Yes No
Do you ever wake up short of breathe? Yes No
Do you use " recreational drugs " such as marijuana, cocaine, crack, LSD or other? Yes No
Have you had a problem with alcohol abuse? Yes No
Do you use tobacco? Yes No
If yes, what form(s) Cigarette Cigar Snuff

Dental Information

Date of last dental visit: _____ Reason for visit: _____
Are you having pain or discomfort at this time? Yes No
Do you feel nervous about having dental treatment? Yes No
Have you ever had any reactions to dental injections? Yes No
Have you ever had difficulty with dental treatment? Yes No
Have you had prolonged bleeding after extractions? Yes No
Do you have any unhealed injuries or sores in or around your mouth? Yes No
Have you been advised on the care of your teeth and gums? Yes No
Do you brush your teeth? Yes No
Do you floss your teeth? Yes No
Do you use mouth rinse? Yes No
Do your gums bleed? Yes No
Do you have any pain in or near your ears? Yes No
Do you habitually clench or grind your teeth during the day or night? Yes No
Do you have any popping, clicking or other noises from your jaw joints? Yes No
Do you have frequent headaches? Yes No
Do you tend to chew on one side? Yes No
When was your last dental cleaning? _____
Where were you last X-rays taken? _____
Have you ever had the following treatments done?
Orthodontic Treatment? Yes No
Periodontal (Gum) Surgery? Yes No
Other major Dental treatment? Yes No
f yes, please explain what kind: _____

To the best of my knowledge, all of the proceeding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

Effective Date: January 14, 2026

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

CONTACT INFORMATION

For more information about our privacy practices, to discuss questions or concerns, or to get additional copies of this notice, please contact our Privacy Officer.
Telephone: 346-388-0505
Lone Star Family Dental
3701 Shaver St, Pasadena, Texas 77504

OUR LEGAL DUTY

We are required by law to protect the privacy of your protected health information ("medical information"). We are also required to send you this notice about our privacy practices, our legal duties and your rights concerning your medical information.
We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect on the date set forth at the top of this page and will remain in effect unless we replace it. We reserve the right at any time to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make any change in our privacy practices and the new terms of our notice applicable to all medical information we maintain, including medical information we created or received before we made the change in practices.
We may amend the terms of this notice at any time. If we make a material change to our policy practices, we will provide to you, the revised notice. Any revised notice will be effective for all health information we maintain. The effective date of a revised notice will be noted. A copy of the current notice in effect will be available in our facility and on our website. You may request a copy of the current notice at any time. We collect and maintain oral, written and electronic information to administer our business and to provide products, services and information of importance to our patients. We maintain physical, electronic and procedural safeguards in the handling and maintenance of our patients' medical information, in accordance with applicable state and federal standards, to protect against risks such as loss, destruction and misuse.

USES AND DISCLOSURES OF YOUR MEDICAL INFORMATION

Treatment: We may disclose your medical information, without your prior approval, to another dentist or healthcare provider working in our facility or otherwise providing you treatment for the purpose of evaluating your health, diagnosing medical conditions and providing treatment. For example, your health information may be disclosed to an oral surgeon to determine whether surgical intervention is needed.
Payment: We provide dental services. Your medical information may be used to seek payment from your insurance plan or from you. For example, your insurance plan may request and receive information on dates that you received services at our facility in order to allow your employer to verify and process your insurance claim.
Health Care Operations: We may use and disclose your medical information, without your prior approval, for health care operations. Health care operations include:

- healthcare quality assessment and improvement activities;
- reviewing and evaluating dental care provider performance, qualifications and competence, health care training programs, provider accreditation, certification, licensing and credentialing activities;
- conducting or arranging for medical reviews, audits and legal services, including fraud and abuse detection and prevention; and
- business planning, development, management and general administration including customer service, complaint resolutions and billing, de-identifying medical information, and creating limited data sets for health care operations, public health activities and research.

We may disclose your medical information to another dental or medical provider or to your health plan subject to federal privacy protection laws, as long as the provider or plan has had a relationship with you and the medical information is for that provider's or

health plan's care quality assessment and improvement activities, competence and qualification evaluation and review activities, or fraud and abuse detection and prevention.

Your Authorization: You (or your legal personal representative) may give us written authorization to use your medical information or to disclose it to anyone for any purpose. Once you give us authorization to release your medical information, we cannot guarantee that the person to whom the information is provided will not disclose that information. You may take back or "revoke" your written authorization at any time, except if we have already acted based on your authorization. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us written authorization, we will not use or disclose your medical information for any purpose other than those described in this notice. We will obtain your authorization prior to using your medical information for marketing, fundraising purposes or for commercial use. Once authorize, you may opt out of these communications at any time.

Family, Friends and Others involved in your care or payment for care: We may disclose your medical information to a family member, friend or any other person you involve in your care or payment for your health care. We will disclose on the medical information that is relevant to the person's involvement.

We may use or disclose your name, location and general condition to notify, or to assist an appropriate public or private agency to locate and notify, a person responsible for your care in appropriate situations, such as a medical emergency or during disaster relief efforts.

We will provide you with an opportunity to object to these disclosures, unless you are not present or are incapacitated or it is an emergency or disaster relief situation. In those situations, we will use our professional judgment to determine whether disclosing your medical information is in your best interest under the circumstances.

Health-Related Products and Services: We may use your medical information to communicate with you about health-related products, benefits, services, payment for those products and services and treatment alternatives.

Reminders: We may use or disclose medical information to send you reminders about your dental care, such as appointment reminders via US Mail, email and telephone. By providing your email address to us, you agree that you may receive reminders and breach notifications via email as a possible alternative to US Mail. It is the policy of our office to leave a message on any voicemail or answering machine that may be attached to a number that you provide (home, cell or work). If you prefer that we NOT leave a message to confirm treatment or your appointments, please check this box. ☐

Plan Sponsors: If your dental insurance coverage is through an employer's sponsored group dental plan, we may share summary health information with the plan sponsor.

Public Health and Benefit Activities: We may use and disclose your medical information, without your permission, when required by law and when authorized by law for the following kinds of public health and public benefit activities;

- for public health, including to report disease and vital statistics, child abuse, adult abuse, neglect or domestic violence;
- to avert a serious an imminent threat to health or safety;
- for health care oversight, such as activities of state insurance commissioners, licensing and peer review authorities and fraud prevention agencies;
- for research;
- in response to court and administrative orders and other lawful process;
- to law enforcement officials with regard to crime victims and criminal activities;
- to coroners, medical examiners, funeral directors and organ procurement organizations;
- to the military, to federal officials for lawful intelligence, counterintelligence, and national security activities, and to correctional institutions and law enforcement regarding persons in lawful custody; and
- as authorized by state worker's compensation laws.

Special protections for SUD records: Substance Use Disorder (SUD) Treatment records have enhanced protections. They cannot be used in legal proceedings without your consent or court order.

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law.

Business Associates: We may disclose your medical information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Data Breach Notification Purposes: We may use your contact information to provide legally required notices of unauthorized acquisition, access or disclosure of your health information.

Additional Restrictions on use and disclosure: Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. "Highly Confidential Information" may include confidential information under Federal laws governing reproductive rights, alcohol and drug abuse information and genetic information as well as state laws that often protect the following types of information:

1) HIV/AIDS;
2) Mental Health;
3) Genetic Tests (in accordance with GINA 2009);
4) Alcohol and drug abuse;
5) Sexually transmitted diseases and reproductive health information; and
6) Child or adult abuse or neglect, including sexual assault.

YOUR RIGHTS

1) You have a right to see and get a copy of your health records.
2) You have a right to amend your health information.
3) You have a right to ask to get an Accounting of Disclosures of when and why your health information was shared for certain purposes.
4) You are entitled to receive a Notice of Privacy Practices that tells you how your health information may be used and shared.
5) You may decide if you want to give your Authorization before your health information may be used or shared for certain purposes, such as marketing. It is the policy of our office NOT to sell or disclose your information to any outside firms or business partners. Your information may be used, only within our office, for the purposes of presenting to you certain products or services which our dentist(s) or staff feel may present a benefit for you, your oral health or happiness with your smile. If you would like to opt out of this level of service, you may do so by checking this box. ☐
6) You have the right to receive your information in a confidential manner and restrict certain communication methods.
7) You have a right to restrict who receives your information.
8) You have a right to request amendment to be made to your health records by submitting the request in writing to our privacy officer. Your request does not guarantee the amendment, but does guarantee that it will be reviewed and considered.
9) If you believe your rights are being denied or your health information is not being protected, you can:
    a. File a complaint with your provider or health insurer
    b. File a complaint with the U.S. Government
10) Right to opt out of fundraising activities. If you would like to opt out of any fundraising programs that our office may participate in, such as cancer walks, or other fundraising programs you may do so by checking this box. ☐

COMPLAINTS

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information, about amending your medical information, about restricting our use or disclosure of your medical information, or about how we communicate with you about your medical information (including a breach notice communication), you may contact our Privacy Officer to register either a verbal or written complaint. You may also submit a written complaint to the Office for Civil Rights of the United States Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, Washington, DC, 20201. You may contact the Office for Civil Rights' hotline at 1-800-368-1019. We support your right to privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the US Department of Health and Human Services.

Patient Signature: _____

Patient Name: _____

Date: _____