PATIENT REGISTRATION

First Name:_______________________________Last Name:_______________________________ Middle Initial:_____
Patient is: Preferred Name:__________________________

☐ Policy Holder

☐ Responsible Party

Patient Information

Address:____ Address 2:____
City:_____________________________________ State/Zip: _____ __________
Home Phone:_____________________ Work Phone:______________________ Mobile:______________________
Sex: Male Female Marital Status: Married Single Divorced Separated Widowed
Birth Date:_________________
Employer: __________________________________ Occupation:____________________________
Email:______________________________________ Referred By:____________________________

Emergency Contact:______________________________ Relationship to patient:_______________________
Emergency Contact Phone:________________________
Preferred Pharmacy:______________________________ Pharmacy Phone:____________________________

Responsible Party (if someone other than the patient)

Address:____ Address 2:____
City:_____________________________________ State/Zip: _____ __________
Home Phone:____________________ Work Phone:______________________ Mobile:___________________
Sex: Male Female Marital Status: Married Single Divorced Separated Widowed
Birth Date: ______________

Primary Insurance Information

Name of insured:___________________________________ Relationship to Insured: Self Spouse Child Other
Insured ID#:____ Insured Birth Date:________________________________
Employer:____ Employer Phone:_________________________________
Insurance Company:_________________________________ Insurance Phone:________________________________
Insurance Group#: __________________________________

Secondary Insurance Information

Name of insured:___________________________________ Relationship to Insured: Self Spouse Child Other
Insured ID#:____ Insured Birth Date:________________________________
Employer:____ Employer Phone:_________________________________
Insurance Company:_________________________________ Insurance Phone:________________________________
Insurance Group#: __________________________________

MEDICAL HISTORY

Patient Name:______________________________ Birth Date:______________________________

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.

Please circle yes or no:

1. Are you under a physician's care now? Yes No If yes, please explain:___________________________

Name of physician:____________________ Phone:_______________ Date of last visit/reason:_______________________________________

2. Have you ever been hospitalized/major operation in last 5 yrs.? Yes No If yes, please explain:_________________________
3. Are you taking any medications, pills, or drugs? Yes No If yes, please list:______________________________

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4. Have you ever premedicated with an antibiotic for dental treatment? Yes No
5. Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No
6. Are you taking a blood thinner? Yes No
7. Do you use tobacco? Yes No If yes, how much and how long:__________________

Women: Are you:

Pregnant/trying to get pregnant? Yes No

Taking oral contraceptives? Yes No

Nursing? Yes No

Men: Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours? Yes No

Are you allergic to any of the following? (please circle all that apply)

Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa Drugs Other

If any apply, please explain:____

Do you have, or have you had, any of the following?

Artificial Heart Valve	Anaphylaxis	Fainting Spells/Dizziness	Mental Disorders
Heart Attack/Failure	Asthma	Liver Disease	Alcohol Addiction
Heart Murmur	Hay Fever	Hepatitis A	Drug Addiction
Heart Pacemaker	Sinus Trouble	Hepatitis B or C	Anxiety
Heart Trouble/Disease	Tuberculosis	Kidney Problems	Depression
High Blood Pressure	Blood Disease	Renal Dialysis	Cold Sores/Herpes
Mitral Valve Prolapse	Anemia	Stomach/Intestinal Disease	Tumors or Growths
Arthritis/Gout	Diabetes Type I or II	Acid Reflux	Ulcer
Artificial Joint	Excessive Bleeding	Bulimia	AIDS/HIV Positive
Osteoporosis	Stroke	Cancer	Venereal Disease
Lung Disease	Alzheimer's Disease	Chemotherapy	Glaucoma
Emphysema	Epilepsy or Seizures	Radiation Treatments	Thyroid Disease

Have you had any serious illness not listed above? If so, please explain:____

Comments:____

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To the best of my knowledge, the questions on this form have been accurately answered. I understand that by 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**___________________

DENTAL HISTORY

Patient Name:_______________________________ Birth Date:_______________________________

Previous Dentist:____________________________________ Date of last dental visit:_____________

Dental History:

1. Do your gums bleed while brushing or flossing? Yes No
2. Are your teeth sensitive to hot or cold liquids/foods? Yes No
3. Are your teeth sensitive to sweet or sour liquids/foods? Yes No
4. Do you feel pain to any of your teeth? Yes No
5. Do you have any sores or lumps in or near your mouth? Yes No
6. Have you had any head, neck or jaw injuries? Yes No
   If yes, please explain:________________________________
7. Have you ever experienced any of the following problems in your jaw?
   Clicking Yes No
   Pain (joint, ear, side of face) Yes No
   Difficulty in opening or closing Yes No
   Difficulty in chewing Yes No
8. Do you have frequent headaches? Yes No
9. Do you clench or grind your teeth? Yes No
   Do you wear a protective mouth guard? Yes No
10. Do you bite your lips or cheeks frequently? Yes No
11. Have you ever had any difficult extractions in the past? Yes No
12. Have you ever had prolonged bleeding after extractions? Yes No
13. Have you had any orthodontic treatment? Yes No
14. Do you wear dentures or partials? Yes No
    If yes, date of placement ____________________________________

Homecare and Nutrition:

1. How often do you brush? ____
2. How often do you floss or clean between the teeth? _____________________________________
3. Specify any other products used for oral care: ____
4. How often do you eat snacks during the day? ____
5. How often do you drink soda or other soft drinks/sports drinks? ____________________________

Please list any questions related to your teeth or oral healthcare that you would like to discuss with us:

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To the best of my knowledge, the questions on this form have been accurately answered. I understand that by 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**__________________

NOTICE OF PRIVACY PRACTICES

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 Health Insurance Portability & Accountability Act of 1996 (“HIPAA”) is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. If you sign a Consent Form, we may use and disclose your medical records only for each of the following purposes: treatment, payment and healthcare operations.

Treatment means providing, coordinating, or managing healthcare and related services by one or more healthcare providers. An example of this would include teeth cleaning services. Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment. Healthcare operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information. We may, without prior consent, use or disclose protected health information to carry out treatment, payment, or healthcare operations in the following circumstances:

In emergency treatment situations, if we attempt to obtain such consent as soon as reasonably practicable after the delivery of such treatment; If we are required by law to treat you, and we attempt to obtain such consent but are unable to contain such consent; or If we attempt to obtain your consent but are unable to do so due to substantial barriers to communicating with you, and we determine that, in our professional judgment, your consent to receive treatment is clearly inferred from the circumstances.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it. The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations. The right to inspect and copy your protected health information. The right to amend your protected health information. The right to receive an accounting of disclosures of protected health information. The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. This notice is effective as of October 17, 2002 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office. You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

□ I do NOT authorize any information to be discussed with any family members or friends.
□ I authorize information about treatment or appointments to be discussed with the following person(s):
____

I have read and understand the above information.

____ ________________________
Patient signature Date

Informed Consent for General Dental Procedures

You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to the treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with accurate information before, during, and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

Please read and initial the items below and sign at the bottom of the form.

1. **Treatment to be Provided**

I understand that during my course of treatment that the following care may be provided:

X Examinations　　X Preventive Services　　X Restorations

X Crowns　　X Bridges　　X Other

Patient Initials _______

2. **Drugs and Medications**

I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues; pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).

Patient Initials_______

3. **Changes in Treatment Plan**

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 give my permission to the dentist to make any/all changes and additions as necessary.

Patient Initials_______

4. **Dental Insurance**

I give my permission to the dental office to bill my dental insurance provider for the treatment provided, if applicable.

Patient Initials_______

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Patient Signature　　Date

BILLING PROCESS AND PRACTICE POLICIES

As doctors whose primary goal is to provide patients with the best in health care services, we would prefer to render our services on the basis of need rather than the ability of patients to pay. We will continue to follow this philosophy but since monetary income is necessary to keep a dental practice in operation we must depend on all patients to pay promptly for services rendered. For this reason we would like you to be aware of our policy on bill payment.

Patients with dental insurance: We will file your claim to the insurance company directly, after you have been treated in our office. Please make sure that we have correct insurance information at your initial visit and keep us informed of any changes. Payment of your "estimated" portion is due at the time services are rendered, such as your annual deductible and/or percentage of the treatment not covered by insurance. We will give your insurance company 45 days to remit payment. Please understand that your insurance policy is a contract between you, your employer and your insurance company. We are not a party to that contract and cannot dictate terms to your insurance company. Should an outstanding balance due result after your insurance company processes your claim, you will then be sent a statement. Payment in full is due by the due date printed on the statement. If you should need special payment arrangements, contact our office immediately to discuss your options. If the balance is still unpaid after 90 days from the date of service, the account will be turned over for further collection action.

Patients without dental insurance: Payment in full is expected at the time services are rendered. We accept cash, check, VISA and MasterCard. Any check that is not cleared through the bank and is returned to our office because of an insufficient balance will be returned to the patient and the patient will be charged $25.00.

Broken/missed appointments: A fee of $65 is charged for patients who miss or cancel more than once in a calendar year with less than 48-hour notice. Please understand that missed time may be convenient to other patients who find it hard to come to the dentist at other times. Please help us serve you better by keeping your scheduled appointments.

Laboratory services: If you are having crowns, dentures or other restorations that must be sent to a dental lab, we require 50% of the fee for that treatment on the day the impressions are made.

We hope by presenting our policies we will avoid any misunderstandings and, therefore, have more time to dedicate to your dental care. If you have any questions regarding the above information please do not hesitate to ask.

By signing below I verify that I understand, agree, and accept the policies outlined above.

Patient Name (print): ________________________________ **Date:** _______________
Responsible Party Signature: ____________________________________
Relationship to Patient: ______________________________