REGISTRATION FORM / MEDICAL HISTORY

PATIENT INFORMATION (CONFIDENTIAL) Date ________________ Home Phone (_____)________________

Name ____________________________________ Birthdate ____________ Soc. Sec. # ________ - ________ - ________

Address ______________________________________ City __________________________ State _____ ZIP ________

Check Appropriate Box ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employed By __________________________________ Occupation ______________ Work Phone (____)__________

Business Address __________________________________ City ___________________ State _____ ZIP ________

Spouse's Name_____________________________ Spouse Employed by_______________Bus. Phone (____)_ _________

Email____________________________________ Who may we thank for referring you?____________________

RESPONSIBLE PARTY

Name of Person Responsible for this Account ________________________________ Relationship to Patient ___________

Address ____ Home Phone (____)____________

Birthdate ______________ Employer Work Phone ___________

Is this person currently a patient of our office? ☐ Yes ☐ No

DENTAL INSURANCE INFORMATION

Name of Insured ____ Relationship to Patient ______________

Insurance Company ____

Group or Employer Name _____________________________________ Subscriber's Soc. Sec. # ____________________

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? ☐ Yes ☐ No

Name of Insured ____ Relationship to Patient ______________

Insurance Company ____

Group or Employer Name _____________________________________ Subscriber's Soc. Sec. # ____________________

MEDICAL HISTORY

Physician ______________________________ Office Phone ______________________ Date of Last Visit ______________

1. Are you under care or treatment now? ☐ Yes ☐ No
2. Have you ever been hospitalized for any surgical operation or serious illness? ☐ Yes ☐ No
3. Do you need to be premedicated due to a recent joint replacement? ☐ Yes ☐ No
4. Are you taking any medication(s) including non-prescription medicine? ☐ Yes ☐ No
   If yes, what medication(s) are you taking? ____
5. Are you allergic to any medication(s)? ☐ Yes ☐ No
   If yes, what? ____
6. Are you wearing contact lenses? ☐ Yes ☐ No
7. Do you smoke? ☐ Yes ☐ No ☐ Cigarettes ☐ Pipe ☐ Cigars How many per day? _____ pack/day
8. Do you use recreational drugs? ☐ Yes ☐ No
9. Women Only
   a) Are you pregnant or think you may be pregnant? .... ☐ Yes ☐ No
   b) Are you nursing? .... ☐ Yes ☐ No
   c) Are you taking birth control pills? .... ☐ Yes ☐ No

(over)

10. Do you have or have you had any of the following?

Yes	No		Yes	No		Yes	No	
☐	☐	High Blood Pressure	☐	☐	Heart Disease	☐	☐	Stomach Ulcers
☐	☐	Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Stroke
☐	☐	Rheumatic Fever	☐	☐	Heart Murmur (MVP)	☐	☐	Hay Fever / Allergies
☐	☐	Thyroid Problem	☐	☐	Angina (Chest Pain)	☐	☐	Tuberculosis
☐	☐	Fainting	☐	☐	Frequently Tired	☐	☐	Radiation Therapy
☐	☐	Seizures	☐	☐	Anemia	☐	☐	Chemotherapy
☐	☐	Asthma	☐	☐	Emphysema	☐	☐	Glaucoma
☐	☐	Low Blood Pressure	☐	☐	Cancer	☐	☐	Recent Weight Loss
☐	☐	Epilepsy / Convulsions	☐	☐	Arthritis	☐	☐	Liver Disease
☐	☐	Leukemia	☐	☐	Joint Replacement	☐	☐	Psychiatric Treatment
☐	☐	Diabetes	☐	☐	Hepatitis / Jaundice	☐	☐	AIDS or HIV Infection
☐	☐	Kidney Disease	☐	☐	Sexually Transmitted Disease	☐	☐	Other

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 clench or grind your teeth? ☐ Yes ☐ No
6. Have you ever had any prolonged bleeding following tooth extractions? ☐ Yes ☐ No
7. Have you ever had periodontal treatment or gum treatment before? ☐ Yes ☐ No
8. Do you gag easily? Yes No
9. When were your teeth last cleaned? Date ____________
10. How often do you brush your teeth? ____________ per day
11. Which of the following do you use?

    Toothbrush: ☐ Soft ☐ Medium ☐ Hard ☐ Dental Floss ☐ Other __________________
12. Are you satisfied or pleased with the way your teeth look? ☐ Yes ☐ No
13. Do you feel very nervous about having dental treatment? ☐ Yes ☐ No
14. What (if anything) would you change about your smile? ____

In order to become a patient at this office, we require a credit card on file. Your card information will be kept completely confidential and stored on a secure server. This card will be debited only in the event that insurance underpays on a claim or an appointment is cancelled with less than 24 hours notice. The fee for a missed appointment or cancellation within 24 hours of a scheduled appointment is $100. Keep in mind that often times insurance companies pay more than we anticipate. In this event, we will have your card on file to credit you the difference for such an overpayment. Please provide information for a card of your choice below and sign to indicate that you accept our cancellation policy.

CC #____ VISA/DISCOVER/MC/AMEX Exp__________ Security #_____

Signature____ Date:__________

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Health Insurance Portability Accountability Act (HIPAA), 1996

http://www.hhs.gov/ocr/hipaa/finalreg.html

SECTION A: PATIENT/GUARDIAN GIVING CONSENT

Name: ______________________ Address: ______________________

Telephone: ______________________ E-mail: ______________________

SECTION B: TO THE PATIENT/GUARDIAN — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

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: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.
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.

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 a personal representative on behalf of the patient signs this Consent, complete the following:

Personal Representative's Name: ______________________

Relationship to Patient: ______________________

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT. PLEASE ADVISE US IF YOU WANT A COPY.

Acknowledgement of Receipt ...Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgement that you have been notified that our *NOTICE OF PRACTICE POLICIES* can be obtained via our office. This document is printable via the web site for your records. **HIPAA web site: http://www.hhs.gov/ocr/hipaa/finalreg.html**

I, ______________________, have received acknowledgement of this office's Notice of Privacy Practices.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: ______________________ Date: ______________________

You May Refuse to Sign This Acknowledgement*

____

For Office Use:

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)

WAIVER FOR NON-COVERED SERVICES

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patient for costs incurred in their case and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time of service.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms and/or assist in making collections from their dental insurance companies. However, this dental office does not render services on the assumption that our charges will be paid by insurance.

Please be advised that any remaining balances from unpaid insurance claims due to **DEDUCTIBLES, FEE SCHEDULES or/and DOWNGRADES** are the patient's responsibility. For example, most dental contracts will reimburse for amalgam (silver) as opposed to white fillings on the posterior teeth when a composite is used. Downgrades may also apply to crowns and other cosmetic services.

I understand that there may be certain services that are not covered by my insurance company. Most elective cosmetic services are not covered by certain dental benefit contracts. Patients are expected to pay for these services in full. Any estimates provided to this practice by my dental insurance company come with a disclaimer stating that benefits are **NOT A GUARANTEE OF PAYMENT**.

I have read the above conditions of treatment and payment and agree to their content.

x____

Patient print

x____

Patient signature