

PATIENT REGISTRATION

ID: _____ Chart ID: _____

First Name: _____ Last Name: _____ Middle Initial: _____

Patient Is: Policy Holder Preferred Name: _____
 Responsible Party

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

Responsible Party is also a Policy Holder for Patient Primary Insurance Policy Holder Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ State / Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: Male Female Marital Status: Married Single Divorced Separated Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic: _____

E-mail: _____ I would like to receive correspondences via e-mail.

Section 2

Employment Status: Full Time Part Time Retired

Student Status: Full Time Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

Section 3

REFERRED BY: _____

EMERGENCY CONTACT #: _____

SPOUSE WORK #: _____

DAD'S WORK #: _____

MOM'S WORK #: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: _____ .00 Rem. Deduct: _____ .00

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: _____ .00 Rem. Deduct: _____ .00

Health History Form

Email: _____ Today's Date: _____

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: Last First Middle	Home Phone: include area code ()	Business/Cell Phone: include area code ()
Address: Mailing address	City:	State: Zip:
Occupation:	Height:	Weight: Date of Birth: Sex: M F
SS# or Patient ID:	Emergency Contact:	Relationship: Home Phone: include area code () Cell Phone: include area code ()

If you are completing this form for another person, what is your relationship to that person?

Your Name	Relationship
Do you have any of the following diseases or problems: (Check DK if you Don't Know the answer to the the question)	
Active Tuberculosis	Yes No DK <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Persistent cough greater than a 3 week duration	Yes No DK <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Cough that produces blood	Yes No DK <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Been exposed to anyone with tuberculosis	Yes No DK <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Referred By:

Dental Information

For the following questions, please mark (X) your responses to the following questions.

Yes No DK	Yes No DK
Do your gums bleed when you brush or floss? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you have earaches or neck pains? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Are your teeth sensitive to cold, hot, sweets or pressure? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you have any clicking, popping or discomfort in the jaw? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Is your mouth dry? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you brux or grind your teeth? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Have you had any periodontal (gum) treatments? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you have sores or ulcers in your mouth? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Have you ever had orthodontic (braces) treatment? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you wear dentures or partials? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Have you had any problems associated with previous dental treatment? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you participate in active recreational activities? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Is your home water supply fluoridated? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Have you ever had a serious injury to your head or mouth? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Do you drink bottled or filtered water? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Date of your last dental exam:
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY	What was done at that time?
Are you currently experiencing dental pain or discomfort? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Date of last dental x-rays:
What is the reason for your dental visit today?	
How do you feel about your smile?	

Medical Information

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

Yes No DK	Yes No DK
Are you now under the care of a physician? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Have you had a serious illness, operation or been hospitalized in the past 5 years? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Physician Name: _____ Phone: include area code ()	If yes, what was the illness or problem?
Address/City/State/Zip:	
Are you in good health? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Are you taking or have you recently taken any prescription or over the counter medicine(s)? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Has there been any change in your general health within the past year? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:
If yes, what condition is being treated?	_____
Date of last physical exam:	_____

Medical Information Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

(Check DK if you Don't Know the answer to the question)

Do you wear contact lenses? Yes No DK

Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? Yes No DK

Date: _____ If yes, have you had any complications? _____

Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax[®], Actonel[®], Atelvia, Boniva[®], Reclast, Prolia) for osteoporosis or Paget's disease? Yes No DK

Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia[®], Zometa[®], XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? Yes No DK

Date Treatment began: _____

Allergies. Are you allergic to or have you had a reaction to: To all **yes** responses, specify type of reaction. Yes No DK

Local anesthetics Yes No DK

Aspirin Yes No DK

Penicillin or other antibiotics Yes No DK

Barbiturates, sedatives, or sleeping pills Yes No DK

Sulfa drugs Yes No DK

Codeine or other narcotics Yes No DK

Do you use controlled substances (drugs)? Yes No DK

Do you use tobacco (smoking, snuff, chew, bidis)? Yes No DK
If so, how interested are you in stopping?
Circle one: VERY / SOMEWHAT / NOT INTERESTED

Do you drink alcoholic beverages? Yes No DK

If yes, how much alcohol did you drink in the last 24 hours? _____

If yes, how much do you typically drink in a week? _____

WOMEN ONLY Are you:

Pregnant? Yes No DK

Number of weeks: _____

Taking birth control pills or hormonal replacement? Yes No DK

Nursing? Yes No DK

Metals Yes No DK

Latex (rubber) Yes No DK

Iodine Yes No DK

Hay fever/seasonal Yes No DK

Animals Yes No DK

Food Yes No DK

Other Yes No DK

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

Artificial (prosthetic) heart valve Yes No DK

Previous infective endocarditis Yes No DK

Damaged valves in transplanted heart Yes No DK

Congenital heart disease (CHD)

Unrepaired, cyanotic CHD Yes No DK

Repaired (completely) in last 6 months Yes No DK

Repaired CHD with residual defects Yes No DK

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

Cardiovascular disease Yes No DK

Angina Yes No DK

Arteriosclerosis Yes No DK

Congestive heart failure Yes No DK

Damaged heart valves Yes No DK

Heart attack Yes No DK

Heart murmur Yes No DK

Low blood pressure Yes No DK

High blood pressure Yes No DK

Other congenital heart defects Yes No DK

Mitral valve prolapse Yes No DK

Pacemaker Yes No DK

Rheumatic fever Yes No DK

Rheumatic heart disease Yes No DK

Abnormal bleeding Yes No DK

Anemia Yes No DK

Blood transfusion Yes No DK

if yes, date: _____

Hemophilia Yes No DK

AIDS or HIV infection Yes No DK

Arthritis Yes No DK

Autoimmune disease Yes No DK

Rheumatoid arthritis Yes No DK

Systemic lupus erythematosus Yes No DK

Asthma Yes No DK

Bronchitis Yes No DK

Emphysema Yes No DK

Sinus trouble Yes No DK

Tuberculosis Yes No DK

Cancer/Chemotherapy/
Radiation Treatment Yes No DK

Chest pain upon exertion Yes No DK

Chronic pain Yes No DK

Diabetes Type I or II Yes No DK

Eating disorder Yes No DK

Malnutrition Yes No DK

Gastrointestinal disease Yes No DK

G.E. Reflux/persistent heartburn Yes No DK

Ulcers Yes No DK

Thyroid problems Yes No DK

Stroke Yes No DK

Glaucoma Yes No DK

Hepatitis, jaundice or liver disease Yes No DK

Epilepsy Yes No DK

Fainting spells or seizures Yes No DK

Neurological disorders Yes No DK

If yes, specify: _____

Sleep disorder Yes No DK

Do you snore? Yes No DK

Mental health disorders Yes No DK

Specify: _____

Recurrent Infections Yes No DK

Type of infection: _____

Kidney problems Yes No DK

Night sweats Yes No DK

Osteoporosis Yes No DK

Persistent swollen glands in neck Yes No DK

Severe headaches/migraines Yes No DK

Severe or rapid weight loss Yes No DK

Sexually transmitted disease Yes No DK

Excessive urination Yes No DK

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? Yes No DK

Name of physician or dentist making recommendation: _____ Phone: Include area code () _____

Do you have any disease, condition, or problem not listed above that you think I should know about? Yes No DK

Please explain: _____

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: _____ Date: _____

Signature of Dentist: _____ Date: _____

FOR COMPLETION BY DENTIST:

Comments: _____

Acknowledgement Of Receipt Of Notice Of Privacy Practices

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

**** You may refuse to sign this acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

Patient Name (Printed)

Signature

Date

Authorization To Release Information

Purpose: This form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself.

I, _____, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

Name (Printed)

Relationship

Name (Printed)

Relationship

Name (Printed)

Relationship

For Office Use Only

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)

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment. Payment is due at the time service is provided. Our office accepts cash, personal checks, credit cards and outside patient financing.

Please check if you would like more information about financing options.

Please Note: Returned checks will be subject to additional fees. If you fail to pay the office on time and it refers your account(s) to a third party for collection, a collection fee of 25% will be assessed and will be due at the time of the referral to the third party. If your account(s) are referred to an attorney or legal action is taken to recover the account(s) a collection fee of 35% will be assessed and will be due at the time of the referral to an attorney or legal action is taken. Such fee will not be assessed in states where it is prohibited by law.

Do You Have Insurance?

- We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company.
- As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however, it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits will determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.
- We ask that you pay the deductible and co-payment, which is the estimated amount, not covered by your insurance company, by cash, check, credit card or Patient Financing at the time we provide the service to you.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

We thank you for the opportunity to serve your dental health care needs and welcome any question you may have concerning your care or our financial policy.

Consent:

I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge and/or attorney fee will be added to any overdue balance. By signing below, you are authorizing us to call you at any number you provide including calls to mobile/cellular or similar devices for any lawful purpose. You agree to any fees or charges that you may incur for an incoming call from us, and/or outgoing calls to us, to or from any such number, without reimbursement from us.

Patient Signature (Parent if child)

Date