PATIENT REGISTRATION AND MEDICAL HISTORY

(PLEASE PRINT)

Date _____ Cell Phone _____

Home Phone _____

E-Mail Address _____

Patient _____
Last Name First Name Initial Preferred Name

Street Address _____ City _____ State _____ Zip _____

Sex: ❑ M ❑ F Age____ Birthdate_____ Driver's License#_____ ❑ Single ❑ Married ❑ Divorced

Patient Employed by _____ Patient Occupation _____

Business Address _____ Business Phone _____

Spouse/Parent Name _____ Spouse/Parent Birthdate _____

Spouse/Parent Employed by _____ Occupation _____ Business Phone _____

Who is responsible for this account? _____ Relationship to Patient _____

Patient Social Security # _____ Spouse/Parent Social Security # _____

Dental Insurance Company 1) _____ 2) _____ Group #s _____

In Case of Emergency, Contact _____ Phone _____

Whom may we thank for referring you? _____

MEDICAL HISTORY

Physician's Name _____ Date of Last Physical _____

Have you ever had any of the following? (check all that apply)

- ❑ Heart Problems
- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Circulatory Problems
- ❑ Nervous Problems
- ❑ Radiation Treatment
- ❑ Artificial Heart Valves or Joints
- ❑ Recent Weight Loss
- ❑ Back Problems
- ❑ Diabetes
- ❑ Latex Allergy
- ❑ Eye Surgery
- ❑ Respiratory Disease
- ❑ Epilepsy
- ❑ Headaches
- ❑ Hepatitis, Jaundice or Liver Disease
- ❑ Cancer
- ❑ Psychiatric Care
- ❑ Chronic Diarrhea
- ❑ Allergies to Anesthetics
- ❑ Allergies to Medicines or Drugs
- ❑ General Allergies
- ❑ Blood Disease
- ❑ Arthritis
- ❑ Special Diet
- ❑ Swollen Neck Glands
- ❑ Taking Bisphosphonate Drugs
- ❑ Sinus Problems
- ❑ A.I.D.S. or Other Immunosuppressive Disorders
- ❑ Stroke
- ❑ Ulcer
- ❑ Venereal Disease
- ❑ Chemical Dependency
- ❑ Hemophilia
- ❑ Taking Natural Supplements

Do you have ANY drug allergies or have you ever had an adverse reaction to ANY medication? If so, what? _____

Have you ever responded adversely to medical or dental treatment? _____

Are you taking ANY medication at this time? _____ If so, what? _____

Are you taking ANY supplements at this time? _____ If so, what? _____

Are you currently under the care of a physician? ❑ Yes ❑ No For what conditions? _____

If patient is a child, what is his/her weight? _____

Do you suspect that you are pregnant? ❑ Yes ❑ No Are you Nursing? ❑ Yes ❑ No

Is there anything else we should know about your medical history? _____

(over please)

PATIENT REGISTRATION & MEDICAL HISTORY

DENTAL HISTORY

Previous Dentist (if applicable) _____ City _____

Date of last cleaning _____ Date of last dental visit_____ Why? _____

Have you had dental x-rays taken during the past three years? ❑ Yes ❑ No If so, what kind: _____

❑ Bitewings (one or two on each side to detect cavities) Date_____

❑ Complete Series (16 x-rays) Date_____

❑ Panorex (sitting or standing and machine moves around head) Date_____

Is there any condition in your mouth that is causing you pain or discomfort? ❑ Yes ❑ No If yes, what kind:_____

_____

Do you do any of the following? (check all that apply)

❑ Bite cheeks or lips	❑ Suck fingers	❑ Breathe through mouth	❑ Drink tea/coffee
❑ Bite tongue	❑ Bite fingernails	❑ Tongue thrust	❑ Chew tobacco
❑ Clench teeth	❑ Suck thumb	❑ Notice bad breath frequently	❑ Smoke (cig/pipe)

Are you satisfied with the appearance of your teeth? ❑ Yes ❑ No

What can we do for you today? _____

_____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance benefits for which I may be entitled. I agree that I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form.

Date_____ Signature_____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance and assign directly to this office's providers, all benefits, if any, otherwise payable to me for services rendered.

I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

_____ _____

Date Signature of Insured/Guardian

FINANCIAL AGREEMENT

By signing below I acknowledge the following: (1) I am responsible for any and all payments or co-payments for services rendered; (2) Any claims submitted to insurance, which are subsequently declined shall become my responsibility; (3) In the event my owed balance should become delinquent, I acknowledge I may additionally become responsible for additional fees including but not limited to: late fees, collection fees, interest, court costs and attorney fees.

_____ _____

Date Signature of Insured/Guardian

MINOR/CHILD CONSENT

I, being the parent or guardian of _____ do hereby request and authorize the dental staff
Name of minor/child

to perform necessary dental services for my child, including but not limited to x-rays, and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

_____ _____

Date Signature of Insured/Guardian

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

ACKNOWLEDGEMENT

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this acknowledgment I authorize you to use and disclose my protected health information to carry out: treatment (including direct or indirect treatment by other healthcare providers involved in my treatment); obtaining payment from third party payers (e.g. insurance company); and in the day-to-day healthcare operations of your practice. The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. You may refuse to sign this acknowledgement and authorization. In refusing we *may not be allowed* to process your insurance claims.

_____ _____

Patient Name (Print) Patient/Legal Representative Signature

Date: _____ _____

Legal Representative Relationship

RELEASE

My signature will also serve as consent to release my information should I request treatment or radiographs be sent to another doctor/facility in the future. Please list any other parties who can have access to your health information:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

CONTACT AUTHORIZATION

Our office continually strives to increase convenience for our patients and improve communications. Accordingly, we would like to communicate with you via telephone, e-mail, and text messaging. The undersigned authorizes contact from this office to communicate information about appointments, treatment, billing, and special services.

_____ _____

Patient Name (Print) Patient/Legal Representative Signature

Date: _____ _____

Legal Representative Relationship

Office Use Only

I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:
It was emergency treatment □ I could not communicate with the patient □ The patient refused to sign □
The patient was unable to sign because other (please describe) _____
Signature of Privacy Officer _____

DECLARATION OF OFFICE POLICIES
&
PATIENT FINANCIAL RESPONSIBILITY

Thank you for choosing our office as your dental care provider. We are committed to your successful treatment. Our trained team will treat you and your family in the most professional manner and will always be willing to answer any questions you may have regarding your treatment or our office policies. We ask that you take a few minutes to review our policies before we begin our relationship. Please let us know if you have any questions or concerns.

***Statement of Financial Responsibility*:** Our office accepts patients that have dental insurance and patients that do not have dental insurance. Regardless of your insurance status, you are financially responsible for treatment provided to you and/or your legal dependent by this office. Payment associated with any treatment is due at the time of service. Our office accepts cash, personal checks (no third-party checks), cashier's checks, and money orders. There is a $30 charge for returned personal checks. We also accept VISA, MasterCard, and Discover credit cards and debit cards for payment. In addition, we also offer third-party financing for your convenience.

This office, as a courtesy, estimates your insurance coverage and will tell you what you can expect to pay. The estimate is just that, an estimate. The estimate is not a guarantee of payment or coverage by your insurance company. Your insurance policy is a contract solely between you and your insurance company. As a courtesy, we will submit a claim to your insurance company for the treatment. By signing this form, you authorize your insurance plan to make payments for covered services directly to our office. You are responsible to pay at the time of service co-pays, deductibles, non-covered services and services provided by this office. If we do not participate with your insurance or benefit plan, or if your insurance company has not paid the claim within 60 days, your balance immediately becomes due and you must pay the balance and then pursue reimbursement directly from your insurance company. If there is a balance on your account, a statement of charges will be sent to your mailing address and you may receive phone calls from this office and/or a third party asset recovery agency. By signing this form, you authorize this office and its agents to communicate with your dental insurance company, in accordance with their Privacy Policy, regarding policy coverage. You further authorize this office to release information to make payment for services rendered.

Please understand that charges over 60 days past due without a payment plan may be sent to an asset recovery agency and may result in being discharged from the practice. By signing this form, you authorize this office and its agents to release your information in order collect past due balances. By signing this form, you understand and accept that there is a $15.00 late fee for amounts past due greater than 60 days. In addition you understand and accept that all collection fees, attorneys' fees and costs are your responsibility.

***Scheduled Appointments*:** If you cannot attend your scheduled appointment you must call to inform us at least 24 hours prior to your appointment. If you fail to call 24 hours prior to your appointment there is a $50.00 charge. That amount cannot be billed to your insurance company. Please make a simple call.

I have read this form and understand my responsibilities.

_____ _____

Signature of Patient or Legal Guardian/Guarantor Date

_____

Printed Name of Patient