## PATIENT REGISTRATION

Date:

Welcome! So that we may provide you with the best possible care, please read and complete ALL pages given. All information is completely confidential.

## OFFICE POLICY

Upon arrival to our office please check in with the receptionist. New patients are asked to bring ALL necessary information regarding their insurance policy. We ask that you bring a list of any MEDICINES taken daily, additional space provided on the DENTAL HISTORY form. If you know of any pre-medication that you must take before each dental appointment, please advise us. We also ask that you notify the receptionist of and CHANGE OF ADDRESS, PHONE NUMBER, INSURANCE INFORMATION OR MEDICAL HISTORY. Waiting

room seating is very limited therefore we ask that only persons with dental appointments and a parent or guardian accompany the patient. If after checking in with the receptionist you find it necessary to use our restroom facilities, please feel free to do so before called into the operatory. This saves everyone concerned valuable time.

1. **APPOINTMENT POLICY** - Our office prides itself on staying on schedule. We ask all of our patients to be on time for their appointment. If you are more than ten (10) minutes late for any scheduled appointment, you will be rescheduled for another date and time. We find it necessary to have this policy in order to be fair to our other patients who arrive on time. We do require 24 hour notice for any appointment that needs to be canceled or rescheduled. A $50.00 broken appointment fee will be charged if the office is not given 24-hours notice. We find it necessary to charge this fee because less than 24-hours notice makes it impossible to fill your scheduled time with another patient. Our office does have an answering machine with date and time stamp for your convenience. The $50.00 fee must be paid before being re-appointed. ANY PATIENTS who fail two (2) scheduled appointments may not be re-appointed.
2. **PAYMENT POLICY** - Payment is expected at the time of service unless other arrangements have been made in writing. If you have insurance, we will gladly bill them as a COURTESY, but you are expected to pay in FULL your portion of the non-covered fees at the time the services are rendered. Our office does accept VISA, MASTERCARD, & DISCOVER credit cards.

I understand these policies as stated above. Patient Signature:

Print Patient Name: Date:

# PATIENT INFORMATION

Patient Name: Date of Birth: Mailing Address: City: Zip:

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status:

 Home Phone: Work Phone: Cell Phone: Social Security Number:

In Case of Emergency Whom May We Contact:

Name: Relationship: Phone Number:

Whom may we THANK for referring you to our office?

# PERSON FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT

Responsible Party Name: Date of Birth: Social Security Number: DL Number: Mailing Address: City: Zip: Employer Name: Phone Number:

Address: City: Zip:

Name of nearest relative not living with you: Phone Number:

# PRIMARY INSURANCE CARRIER

Insurance Company Name: Employee Name: Group Number: Company Address: Telephone: Employer Name: Date of Hire: Date of Birth: Employee Social Security Number:

## PATIENT CONSENT FORM

I understand that I have the rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1998 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

* Treatment (including direct or indirect treatment by other health care providers involved in my treatment),
* Obtain payment from third party payers (e.g. My insurance company)
* The day-to-day health care operations of your practice

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights on HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent in writing at any time. However, any use of disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this day of , 20 . Print Patient Name: Relationship to Patient: Signature:

## DENTAL HEALTH HISTORY

Confidential

Patient Name: Date:

Last First Initial

**DENTAL HISTORY**

Reason for Today’s Visit Date of last dental care:

Former Dentist: Date of last dental x-rays:

Address:

Check () if you have had problems with any of the following:

|  |  |  |  |
| --- | --- | --- | --- |
| Bad breath | Grinding teeth |  Sensitivity to hot | Bleeding gums |
| Loose teeth/broken fillings | Sensitivity to sweets | Clicking/popping jaw | Periodontal treatment |
| Sensitivity when biting | Food collection between teeth | Sensitivity to cold | Sores/growths in mouth |

How often do you floss? How often do you brush?

**MEDICAL HISTORY**

Physician’s Name: Date of last visit:

Have you had any serious illnesses or operations? If yes, please describe:

Have you ever had a blood transfusion?  Yes  No If yes, give approximate date(s):

Have you ever taken any of the group of drugs collectively referred to as “fen-phen”? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine.)  Yes  No

(Women) Are you pregnant?  Yes  No Nursing?  Yes  No Taking birth control pills?  Yes  No Check () if you have or have had any of the following:



|  |  |  |  |
| --- | --- | --- | --- |
| Anemia |  Cortisone Treatments |  Hepatitis | Scarlet Fever |
| Arthritis, Rheumatism |  Cough, Persistent |  High Blood Pressure |  Shortness of Breath |
| Artificial Heart Valves |  Cough up Blood |  HIV/AIDS |  Skin Rash |
| Artificial Joints |  Diabetes |  Jaw Pain |  Stroke |
| Asthma |  Epilepsy |  Kidney Disease |  Swelling of Feet/Ankles |
| Back Problems |  Fainting |  Liver Disease |  Thyroid Problems |
| Blood Disease |  Glaucoma |  Mitral Valve Prolapse |  Tobacco Habit |
| Cancer |  Headaches |  Radiation Treatment |  Tuberculosis |
| Chemotherapy |  Heart Problems |  Respiratory Disease |  Ulcer |
| Circulatory Problems |  Hemophilia |  Rheumatic Fever |  Venereal Disease |

List medications you are currently taking:  Aspirin  Penicillin  Barbiturates (Sleeping pills)  Sulfa

**MEDICATIONS**

**ALLERGIES**

 Codeine  Latex

 Local Anesthetic  Other

Pharmacy Name: Phone:

**SIGNATURE**

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signature of Patient, Parent, Guardian or Personal Representation Date

Please print name of Patient, Parent, Guardian or Personal Representation Relationship to Patient

Submit