Today's Date_____ **PATIENT REGISTRATION AND MEDICAL HISTORY**

Cell Phone _____

Home Phone_____

Patient_____
Last Name First Name Middle Initial Preferred Name

Mailing Address_____ Lot/Apt. _____City _____ State_____ Zip_____
Street Address _____ Lot/Apt. _____City _____ State _____ Zip _____
Sex ()M ()F Age _____ Birthdate_____ ()Single ()Married () Widowed ()Separated () Divorced
Employed by_____ Occupation_____
Business Address_____ Business Phone_____
Spouse/Parent Name_____ Spouse/Parent Birthdate_____
Spouse/Parent Employed by_____ Occupation_____
Business Address_____ Business Phone_____
Who is responsible for this account?_____ Relationship to Patient_____
Patient's Social Security #_____ Spouse/Parent Social Security #_____
Name of Primary Dental Insurance Company_____ Group #_____
Insured Name _____ Insured DOB _____ Subscriber ID#_____
Name of Secondary Dental Insurance Company _____ Group #_____
Insured Name_____ Insured DOB _____ Subscriber ID#_____
Emergency Contact Name of Relative or Person NOT LIVING with you_____ Ph._____
Whom may we thank for referring you? _____ Email _____

MEDICAL HISTORY

Physician's Name_____ Date of Last Physical_____
Have you ever had any of the following? (check boxes that apply)

() Heart Problems
() High Blood Pressure
() Low Blood Pressure
() Circulatory Problems
() Nervous Problems
() Radiation Treatment
() Artificial Heart/Valves or Joints
() Back Problems
() Diabetes
() Need Antibiotic Prior to Dental Work
() Epilepsy
() Hepatitis, Jaundice, Liver Disease
() Cancer
() Psychiatric Care
() Allergies to Anesthetics
() Allergies to Medicines or Drugs
() General Allergies
() Blood Disease
() Arthritis
() Respiratory Disease/() TB
() Rheumatic Fever
() Sinus Problems
() A.I.D.S. or other Immunosuppressive Disorders
() Stroke
() Venereal Disease
() Chemical Dependency
() Hemophilia, Prolonged Bleeding
() Subject to Fainting
() Drug or Substance Addiction

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 currently taking a blood thinner? () Yes () No If so, what?_____
Are you taking any other medication at this time? () Yes () No If so, what?_____
Are you under the care of a physician? () Yes () No For what condition? _____
If patient is a child, what is his/her weight?_____
(Women) Do you suspect that you are pregnant? () Yes () No How far?_____ Are you nursing? () Yes () No
Is there anything else we should know about your medical history?_____

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 for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any error or omissions that I may have made in the completion of this form. I understand that it is my responsibility to inform this office of future changes in my medical history, dental insurance and contact information.

Signature _____ Date _____

DENTAL HISTORY

Reason for today's visit? _____

Last Dental visit _____

How often do you brush? _____

What dental aids do you use? ( ) Floss, ( ) Water Pick ( ) Toothpick ( ) Electric/Sonicare Toothbrush
( ) Perio Aid ( ) Other _____

When used properly, do you believe in the dental benefits of Fluoride? ( ) Yes ( ) No

Please check any of the following which apply to you:

( ) Gums bleed during brushing or flossing
( ) Pain with brushing or flossing
( ) Frequent sensitivity to cold, hot or sweets
( ) Usually break fillings or teeth
( ) Jaws frequently feel tired or sore
( ) Regularly clench or grind your teeth
( ) Bad odors or tastes in mouth
( ) Gums feel tender or swollen
( ) Food frequently gets caught between teeth
( ) Previous (or current) Periodental (gum) surgery
( ) Pain with biting or chewing
( ) Previous (or current) biopsy of the mouth, lips or face
( ) Frequent cold sores, blisters or other oral/lip lesions
( ) Previous (or current) injury or trauma to your teeth, mouth or face

CONSENT FOR TREATMENT (please sign unless you have any questions)

I hereby authorize this Dental Practice to administer and perform the necessary procedures, such as x-rays, anesthetics and dental treatment deemed necessary or advisable with the diagnosis of my dental condition. I understand there are certain risks inherent in dental treatment; such as but not limited to: pulpal sensitivity or damage, tissue swelling or bruising, soreness of jaws, paresthesia and other procedure specific risks.

Insurance Release:

I authorize release of information regarding my dental treatment to my insurance carrier. I agree to be responsible for payment on services rendered during my ineligible insurance period and any balance not paid by the insurance carrier. I understand that insurances are billed as a courtesy and that I am ultimately responsible for all costs of treatment.

Financial Responsibility for Payment:

I acknowledge that payment is due at the time of treatment unless other arrangements are made. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor/child.
I accept full financial responsibility for all charges not covered by insurance. I will pay for services if they exceed the insurance benefit limitations.
The undersigned further agrees to pay a finance charge of 1 ½% per month on the unpaid balance of this account.
In the event that this matter is turned over to a collection agency or attorney for collection of any of the fees due herein; I hereby agree to pay all collection agency fees and all attorney fees, whether or not a lawsuit is instituted. I also acknowledge that I would be responsible for all court costs incurred in making collection of sums due and unpaid for the work herein set forth.

Signature _____ Date _____

MINORS OR CHILD CONSENT

Because (name of child)_____ is a minor, it is necessary that signed permission be obtained from a parent or guardian before any dental services are rendered. Such authorization is hereby granted. Furthermore, I agree to be responsible for any bills incurred on behalf of this child during their dental treatment.

Signature _____ 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.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records. Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, and have copies available in our office.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office.

I have read and understand this form. I am signing it voluntarily. I authorize the disclosure of my health information as described in this form.

Patient Name _____

Signature _____ Date _____