REGISTRATION

Thank You for selecting Our Dental Team

Patient Information (Confidential)

Name _____ Date _____

SS#/SIN _____ Birthdate _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Email _____ Cell Phone _____

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

If Student, Name of School / College _____ City _____ State _____ ☐ Full Time ☐ Part Time

Patient or Parent/Guardian's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Email _____ Cell Phone _____

Birthdate _____

Employer _____ Work Phone _____ SS#/SIN _____

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

☐ Cash ☐ Personal Check ☐ VISA ☐ MasterCard ☐ Discover ☐ AMEX ☐ I wish to discuss the office's payment policy.

Insurance Information – DENTAL

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Policy/ID # _____

Do You Have Any Additional Insurance? ☐ Yes ☐ No If Yes, Complete the Following

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Policy/ID # _____

Patient Medical History

Name of Physician _____ Location _____ Phone _____

Are you under medical treatment now? Y N

Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? Y N

If yes, explain _____

Are you or have you ever been addicted to a chemical substance? Y N

Have you undergone current or past osteoporosis therapy? Y N
(examples: fosamax, actonel, boniva pill form)

Have you undergone current or past therapy to reduce high blood calcium? (Bisphosphonate therapy?) Y N
(examples: intravenous aredia, zometa)

Are you wearing contact lenses? Y N

Women only

Are you pregnant or think you may be pregnant? Y N

Are you nursing? Y N

Are you taking oral contraceptives? Y N

Allergies:

Aspirin	Y	N
Barbiturates (sleeping pills)	Y	N
Codeine	Y	N
Iodine	Y	N
Latex	Y	N
Local Anesthetic	Y	N
Penicillin	Y	N
Sulfas	Y	N
Any Metals (nickel, mercury, etc.)	Y	N
Other _____		

Are you taking any medication(s) including non-prescription medicine? Y N

List the medication(s) here:

_____

_____

_____

_____

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

AIDS or HIV infection	Y	N	**Joint Replacement** What?	Y	N
Anemia	Y	N	When?		
Angina/Chest Pains	Y	N	Kidney Disease	Y	N
Acquired Valvular Disease or Heart Murmur	Y	N	Liver Disease	Y	N
Arthritis/Rheumatism	Y	N	Low Blood Pressure	Y	N
Artificial Heart Valve Replacement	Y	N	Mental Health Condition	Y	N
Asthma	Y	N	Mitral Valve Prolapse	Y	N
Bacterial Endocarditis History	Y	N	**Organ Transplantation**	Y	N
Blood Disease	Y	N	Physical disability that may require special		
Cancer Type: _____	Y	N	care? (impairment of hearing, sight, speech)	Y	N
Cardiac Pacemaker	Y	N	**Physician Requests Antibiotic Coverage**		
Chemo/Radiation	Y	N	**for any reason not listed**	Y	N
Congenital Heart Disease Type: _____	Y	N	Recent Weight Loss	Y	N
Congestive Heart Failure	Y	N	Respiratory Problems	Y	N
Cough, Persistent or Bloody	Y	N	Rheumatic Fever	Y	N
Diabetes Type: _____	Y	N	Scarlet Fever	Y	N
Emphysema	Y	N	Sexually Transmitted Disease	Y	N
Epilepsy/Convulsions	Y	N	Sinus Trouble	Y	N
Fainting/Seizures	Y	N	Stomach Trouble/Ulcers	Y	N
Glaucoma	Y	N	Stroke	Y	N
Heart Attack	Y	N	Swollen Ankles/Feet	Y	N
Heart Surgery	Y	N	**Systemic Lupus Erythematosus (SLE)**	Y	N
Hepatitis Type: _____	Y	N	Thyroid Problem	Y	N
High Blood Pressure	Y	N	Tuberculosis/Lung Disease	Y	N
Jaundice	Y	N	Other		

Patient Dental History

Name of Previous Dentist _____ Date of last dental visit _____

Previous Dentist Location _____ Recent X-rays _____

Reason for today's visit _____

Do your gums bleed when brushing or flossing?	Y	N
Are your teeth sensitive to:		
Hot or Cold? Y N Sweet or Sour? Y N Biting Pressure? Y N		
Do you have any sores or lumps in or near your mouth?	Y	N
Have you had any head, neck or jaw injuries?	Y	N
Do you have frequent headaches?	Y	N
Have you experienced any of the following?		
Clicking	Y	N
Pain (joint, ear, side of face)	Y	N
Difficulty in opening or closing	Y	N
Difficulty in chewing	Y	N
Do you clench or grind your teeth?	Y	N
Do you bite your lips or cheeks frequently?	Y	N
Does food collect between your teeth?	Y	N
Do you have dry mouth?	Y	N
Do you use tobacco?	Y	N
Have you ever had any prolonged bleeding following extractions?	Y	N
Have you ever had any trouble associated with previous dental treatment?	Y	N

Circle the type(s) of dental treatment you have experienced:

Orthodontics (braces) ☐	Implants ☐
Oral Surgery ☐	Periodontal (gum) treatment ☐
Dentures ☐	TMJ Treatment ☐
Root Canal Treatment ☐	Fillings ☐

Are you happy with the appearance of your teeth?	Y	N

If no, please explain _____

Consent

1. The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient) _____ . I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that all 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 other arrangements have been made. In the event payments are not received by the agreed upon dates. I understand that a 1 - 1/2% finance charge (18% APR) may be added to my account in addition to any collection charges.
4. I understand that where appropriate, credit bureau reports may be obtained.
5. I understand that it is my responsibility to advise your office of any changes in the information contained on this form.

Patient _____ Date _____ Witness _____

Parent or Responsible Party _____ Relationship to Patient _____

FOR OFFICE USE Reviewed by Dr. _____ Date _____

PATIENT CONSENT FORM

The Department of Health and Human Services has established a " Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal dental records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment, or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal dental records. We may have indirect treatment relationships with you (such as laboratories that only interact with doctors and not patients), and may have to disclose personal health information for purposes of treatment, payment, of health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of you PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Patient Name: _____

Signature (patient or guardian): _____

Date: _____