

PATIENT REGISTRATION

ID: _____ Chart ID: _____
 First Name: _____ Last Name: _____ Middle Initial: _____
 Patient Is: Policy Holder Responsible Party Preferred Name: _____

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.

<p>Section 2</p> <p>Employment Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired Student Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time Medicaid ID: _____ Pref. Dentist: _____ Employer ID: _____ Pref. Pharmacy: _____ Carrier ID: _____ Pref. Hyg: _____</p>	<p>Section 3</p> <p>CC # _____ Exp Date _____ Amt _____ Date to charge _____</p>
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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: _____ Rem. Deduct: _____

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: _____ Rem. Deduct: _____

Patient Name:

Birth Date:

Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Are you under a physician's care now? Yes No If yes _____

Have you ever been hospitalized or had a major operation? Yes No If yes _____

Have you ever had a serious head or neck injury? Yes No If yes _____

Are you taking any medications, pills, or drugs? Yes No If yes _____

Do you take, or have you taken, Phen-Fen or Redux? Yes No If yes _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No If yes _____

Are you on a special diet? Yes No

Do you use tobacco? Yes No

Do you use controlled substances? Yes No If yes _____

Women: Are you...

Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic
 Metal Latex Sulfa Drugs Local Anesthetics

Other? If yes _____

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

AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No	Hemophilia <input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No	Diabetes <input type="radio"/> Yes <input type="radio"/> No	Hepatitis A <input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No	Drug Addiction <input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No
Anemia <input type="radio"/> Yes <input type="radio"/> No	Easily Winded <input type="radio"/> Yes <input type="radio"/> No	Herpes <input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No
Angina <input type="radio"/> Yes <input type="radio"/> No	Emphysema <input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Rheumatism <input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No	High Cholesterol <input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No	Hives or Rash <input type="radio"/> Yes <input type="radio"/> No	Shingles <input type="radio"/> Yes <input type="radio"/> No
Artificial Joint <input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No
Asthma <input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No
Blood Disease <input type="radio"/> Yes <input type="radio"/> No	Frequent Cough <input type="radio"/> Yes <input type="radio"/> No	Kidney Problems <input type="radio"/> Yes <input type="radio"/> No	Spina Bifida <input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No	Leukemia <input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No
Breathing Problems <input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No	Liver Disease <input type="radio"/> Yes <input type="radio"/> No	Stroke <input type="radio"/> Yes <input type="radio"/> No
Bruise Easily <input type="radio"/> Yes <input type="radio"/> No	Genital Herpes <input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No
Cancer <input type="radio"/> Yes <input type="radio"/> No	Glaucoma <input type="radio"/> Yes <input type="radio"/> No	Lung Disease <input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No
Chemotherapy <input type="radio"/> Yes <input type="radio"/> No	Hay Fever <input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No	Tonsillitis <input type="radio"/> Yes <input type="radio"/> No
Chest Pains <input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No	Osteoporosis <input type="radio"/> Yes <input type="radio"/> No	Tuberculosis <input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No	Heart Murmur <input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No	Ulcers <input type="radio"/> Yes <input type="radio"/> No
Convulsions <input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No	Veneraal Disease <input type="radio"/> Yes <input type="radio"/> No
			Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No

Have you ever had any serious illness not listed above? Yes No If yes _____

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian: _____

X Date: _____

Patient Consent & Authorization for Release of Protected Health Information

Please Print

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ ZIP Code: _____ Telephone Number: _____

E-mail Address: _____

Patient Authorization

I, _____, hereby authorize the release, use or disclosure of my health information as follows:

This authorization pertains to the following type of medical information about me:

I hereby authorize Kuechle and Truitt, D.D.S.
Name of individual(s) and/or organization providing information

to release the above-described information to _____
Name of individual(s) and/or organization receiving this information

I understand that, per my request, this authorization will permit the above-named parties to use or disclose the identified health information for purposes beyond treatment, payment, or healthcare operations as provided by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I understand that I may revoke this authorization at any time by providing written notification to:

The revocation will be effective on the date it has been received and processed by the above-named recipient. I understand that the revocation does not apply to actions taken in reliance upon this authorization prior to the effective date of revocation. I also understand that I do not have to sign this authorization in order to receive treatment, payment, or to enroll or be eligible for benefits.

Unless I request in writing otherwise, I understand that this authorization will expire on _____, If I do not specify an expiration date or event, this authorization will expire ninety (90) days from the date on which I signed this authorization.

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the named recipient, and may no longer be protected by HIPAA's privacy rules after the authorized disclosure.

Patient or Personal Representative

Signature: _____ Date: _ / _ / _

Name: _____
Please Print

Relationship to Patient: _____

For Office Use Only

Received by: _____ Date: _ / _ / _

WELCOME TO DR KUECHLE & IRVING'S DENTAL OFFICE

We hope you will find that our office takes pride in running as efficiently as possible. In order to accomplish this, we would like to take a few minutes to review our office policies. If you have any questions regarding these policies, please do not hesitate to ask any staff member.

APPOINTMENTS:

We will call you to remind you of all appointments as a courtesy to you. However, **YOU** will be held responsible for keeping track of your appointments. It is imperative that you notify our office at least 24 hours in advance if you need to cancel your appointment. If you do not provide us with 24 hour notification, **YOU WILL BE CHARGED** the missed appointment fee.

OFFICE FEES:

Unless you are covered by an insurance plan that we participate with, payment must be made at the time of your office visit. **NO EXCEPTIONS!** You can pay by cash, check, money order, MC, Visa, Discover, American Express, or debit card.

SCHEDULED APPOINTMENT TIMES:

The Doctors and Hygienists are very prompt and generally run true to their scheduled appointments. However, there are occasional emergencies which may cause them to run late. Unfortunately, some patients arrive late which delays the Doctor. If you are significantly (over 15 minutes) it may be necessary to reschedule your appointment.

RETURNED CHECKS:

If your check is returned for non-sufficient funds, you expressly authorize your account to be electronically debited or bank drafted for the amount of the check plus any applicable fees. The use of a check for payment is your acknowledgment and acceptance of this policy and its terms and conditions.

Thank you for your consideration. We feel that these policies will enable our office to run smoothly and allow us to spend more time on your dental concerns.

Patient's Signature

Date