Knight Family Dentistry

PATIENT REGISTRATION

First Name:_____ **Last Name:**_____ **Preferred Name:** _____

Social Security # (if over 18):_____-_____-_____ **Birthday:** _____/_____/_____ **Sex**: M or F	Street Address: _____ Apt:_____ City:_____ State_____ Zip Code: _____
Home Phone: _____-_____-_____ Work Phone:_____-_____-_____ **Cell Phone:** _____-_____-_____	**Email**:_____ I **would** like to receive appointment reminders via email YES / NO **Referred by:**_____
Marital Status (Please Circle): Single / Married / Partnered / Widowed	**Emergency** Contact Name:_____ Relationship to pt:_____ Phone: _____-_____-_____

Guarantor (if pt is a minor):_____**DOB:**_____**SS#:**_____

Primary Insurance Information: Name of Insured:_____ Relationship to Patient:_____ Insured's Employer:_____ Insurance Company:_____ Member/ Subscriber ID:_____ Group #: _____ Insurance Phone #: _____	FLEX SPENDING / HEALTH SAVINGS ACCOUNT(please circle one) **YES / NO**
Secondary Insurance Information: Name of Insured:_____ Relationship to Patient:_____ Insured's Employer:_____ Insurance Company:_____ Member/ Subscriber ID:_____ Group #: _____ Insurance Phone #: _____	CARE CREDIT (please circle one) **YES / NO**

Your appointment is very important to us and it is reserved especially for you. We realize that there can be some unexpected things that come up in our lives. While truly sympathetic, when a patient cancels without giving enough notice, they prevent another patient from being seen by our office. Knight Family Dentistry has a minimum 24 hour cancellation/rescheduling policy. If an appointment is missed, canceled or changed with less than 24 hours notice, the patient will be charged a $25 cancellation fee for the first missed appointment, a $50 cancellation fee for the second missed appointment and then will be dismissed from the practice.

I UNDERSTAND THAT MY **DENTAL INSURANCE IS A CONTRACT BETWEEN THE INSURANCE COMPANY AND ME, AND NOT BETWEEN THE INSURANCE CARRIER AND KNIGHT FAMILY DENTISTRY/AMERICAN DENTAL OF EASTMAN. I AM ULTIMATELY RESPONSIBLE FOR ALL DENTAL FEES. THESE FEES ARE DUE AND PAYABLE AT THE TIME OF SERVICE.**

ANY PAYMENTS RECEIVED BY KNIGHT FAMILY DENTISTRY/AMERICAN DENTAL OF EASTMAN **OFFICE FROM MY INSURANCE COMPANY WILL BE CREDITED TO MY ACCOUNT, OR REFUNDED TO ME, UPON REQUEST IF I HAVE PAID THE DENTAL FEES INCURRED.**

_____ _____

Patient or Guardian Signature **DATE**

Dental History - Please mark (✓) any of the following conditions that apply to you

Periodontal (Gum) Health
- ❑ Bleeding, Swollen, Irritated gums
- ❑ Bad breath
- ❑ Loose tipped, shifting teeth
- ❑ Previous perio/gum disease

Pain/Discomfort
- ❑ Sensitivity (hot, cold, sweet)
- ❑ Pressure
- ❑ Broken teeth/fillings
- ❑ Worn teeth
- ❑ Dry Mouth

Habits
- ❑ Thumb sucking
- ❑ Nail-biting
- ❑ Cheek/Lip biting
- ❑ Chewing on ice/foreign objects

Function
- ❑ Grinding/Clenching
- ❑ Headaches
- ❑ Jaw Joint (TMJ) pain
- ❑ Jaw Joint (TMJ) clicking/popping
- ❑ Bad Bite
- ❑ Speech Impediment
- ❑ Mouth Breathing
- ❑ Sore Muscles (neck, shoulders)
- ❑ Difficulty Opening or Closing
- ❑ Difficulty Chewing on either side

Comfort w/Dental Treatment
- ❑ Fear (dentists, needles, drill, etc)
- ❑ Anxiety
- ❑ Bad dental experiences
- ❑ Noises

Appearance
- ❑ Discolored teeth
- ❑ Worn teeth
- ❑ Misshaped teeth
- ❑ Crooked teeth
- ❑ Spaces
- ❑ Overbite
- ❑ Flat teeth

Sleep Pattern or Conditions
- ❑ Sleep Apnea
- ❑ Snoring
- ❑ Daytime Drowsiness
- ❑ Bed wetting (for children)

Social
- ❑ Tobacco How much__ How long__
- ❑ Alcohol Frequency_____
- ❑ Drugs Frequency_____

Please share the following dates:

Your last cleaning _____/_____

Your last oral cancer screening_____/_____

Your last complete X-rays _____/_____

Name of your previous dentist

_____

City_____

State_____

Phone_____

Why did you leave?

_____

On a scale of 1-10, with 10 being the highest rating, rate your smile

_____

Rate where you'd like it to be

_____

What would you like to change about your smile?
- ❑ Color
- ❑ Chipped Teeth
- ❑ Crowding
- ❑ Missing Teeth
- ❑ Bite
- ❑ Spaces
- ❑ Smile Makeover
- ❑ Whiter Teeth

Please use this space to explain any past dental experiences that you feel we should know in order to treat you to the best of our abilities

I, THE UNDERSIGNED, HEREBY AUTHORIZE KNIGHT FAMILY DENTISTRY/AMERICAN DENTAL OF EASTMAN PROVIDERS TO TAKE X-RAYS, STUDY MODELS, PHOTOGRAPHS, OR ANY OTHER DIAGNOSTIC AIDS DEEMED APPROPRIATE BY THE DOCTOR TO MAKE A THOROUGH DIAGNOSIS OF MY DENTAL NEEDS.

_____ _____

Patient/Guardian Signature Date

Medical History - Please mark (✓) to your response to indicate if you *have* or have had any of the following

Cardiovascular
- ❑ Angina (chest pain)
- ❑ Heart Attack/Myocardial Infarction
- ❑ Artificial/Prosthetic Heart Valve
- ❑ Heart Conditions
- ❑ Heart Surgery
- ❑ High Blood Pressure/Hypertension
- ❑ Low Blood Pressure
- ❑ Mitral Valve Prolapse
- ❑ Pacemaker
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Infective Endocarditis
- ❑ Congestive Heart Failure
- ❑ Heart Bypass or Stent

Endocrinology
- ❑ Diabetes
- ❑ Hepatitis
  - ❑ A
  - ❑ B
  - ❑ C
- ❑ Jaundice
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Thyroid Disorder: _____

Respiratory
- ❑ Asthma
- ❑ Emphysema/bronchitis/COPD
- ❑ Sinus Problems
- ❑ Sleep Apnea
  - ❑ If yes; do you wear a CPAP or BIPAP? _____
- ❑ Tuberculosis
  - ❑ Year:_____
  - ❑ Treatment:_____ _____
- ❑ Respiratory Problems: _____ _____ _____

Women
- ❑ Currently Pregnant
  - ❑ Due date?_____
- ❑ Currently Nursing/plan to nurse in the next 6 months

Gastrointestinal
- ❑ Ulcers (Stomach)
- ❑ Gastrointestinal Disease
- ❑ GERD/Acid reflux

Hematologic/Lymphatic
- ❑ Anemia
- ❑ Blood Disorders
- ❑ Bruise Easily
- ❑ Excessive Bleeding
- ❑ Sickle cell disease/trait
- ❑ Leukemia/lymphoma
- ❑ Coumadin/warfarin treatment (blood thinners)
- ❑ AIDS
- ❑ HIV Positive

Neurological
- ❑ Dizziness
- ❑ Fainting
- ❑ Seizures
- ❑ Psychiatric illness: _____
- ❑ Vasovagal syncope
- ❑ Stroke/TIA/Mini-stroke
- ❑ Multiple Sclerosis
- ❑ Epilepsy

Musculoskeletal
- ❑ Artificial Joints (please list which joint and what year it was done) _____ _____ _____ ___
- ❑ Jaw Joint Pain
- ❑ Rheumatoid Arthritis
- ❑ Osteoarthritis

OTHER
- ❑ Anxiety
- ❑ Depression
- ❑ Drug/Alcohol Addiction
- ❑ Organ transplant
  - ❑ When and what organ(s)?_____ _____ _____
- ❑ Are you on dialysis? _____

Cancer: Type(s)
_____
_____
- ❑ Chemotherapy
- ❑ Radiation Therapy
- ❑ use/used Bisphosphonate medication for osteoporosis OR cancer
- ❑ Medications: _____ _____ _____

Please list ALL prescription OR over the counter medicine(s) you are CURRENTLY or RECENTLY have taken. If you can not remember any or all of them, please let us know and we will discuss how to get a copy of your medication list to us. Include vitamins, natural or herbal supplements and/or dietary supplements --if you need more room, please check this box [ ] and continue on back of last sheet in this packet

Medication Name	Dosage	Why you are taking this medication

Medical History Continued

Are you under the care of a physician? Y or N **If yes**, please explain:

_____

Physician: Name_____ Address:_____ Phone(_____)_____

Are you under the care of a Cardiologist (heart doctor)? Y or N **If yes**, please explain:

_____

Cardiologist: Name_____ Address:_____ Phone(_____)_____

In the past 5 years, have you had a serious illness, operation, or hospitalization? Y or N **If yes**, please list below what it was and the month/year:

_____

_____

_____

List all Medications or Substitutes you are Allergic to:	Have you **ever** had surgery? If so, what type and when:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Height: _____ **Weight:_____** **BMI= _____= weight (lbs) x 703/ height^2(m)**

Consent:

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. I also authorize the Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read, understand and agree to the above terms and conditions.

_____ _____

Signature of Patient/Legal guardian **Date**

Office Financial Policy

In an effort to maintain treatment fees at a minimum while maintaining a high level of professional care, we have established the following financial policy for our office. Before any dental treatment is begun, the patient and/or responsible party will receive a consultation regarding treatment plan and cost.

- A **current Insurance** card is required by each patient at the time of each visit.
- At the time of each visit, please notify the staff if there have been any changes to personal information or if the Dental Van has seen the patient recently.
- Parents being seen by the provider should have someone attend to their children that are brought into the office, children **CANNOT** be in the treatment room or left alone in the lobby while the parent is receiving treatment. Children not receiving treatment should not be in the office due to safety concerns.
- Parents are **NOT** allowed to accompany the child while they are receiving dental treatment unless the provider or his/her assistant requests the parent's presence during the treatment.
- **For the safety of your children, parent(s)/guardian(s) over 21 are required to remain in the building for any child 17 years or younger for the duration of their dental visit.**

Insurance:

We require payment in full for the portion, not covered by dental insurance, of dental services to be rendered. For procedures that take multiple appointments to complete, payment may be split up over the number of appointments required. We accept cash, Amex Visa, MasterCard, Discover, and upon request, we can also provide information regarding financial companies to help assist with the cost of your dental procedures such as Care Credit. Credit applications for such financing options are available upon request.

As a courtesy to our patients with insurance, we will file your insurance claim, allowing you to pay only your deductible and/or **estimated** co-payment as services are rendered. Please remember that the contract is between you and your insurance company and your **total balance in our office is always your responsibility. Please note that we allow 60 days for dental claims to be paid.** However, we have no way to guarantee the actual terms of your policy. If for any reason there is a balance remaining after your insurance company's payment, you will be sent a statement. Any dispute regarding reimbursement or the amount of reimbursement is between you and your insurance carrier.

Appointments: ***Your appointment is very important to us and it is reserved especially for you. We realize that there can be some unexpected things that come up in our lives. While truly sympathetic, when a patient cancels without giving enough notice, they prevent another patient from being seen by our office. Knight Family Dentistry has a minimum 24 hour cancellation/rescheduling policy. If an appointment is missed, canceled or changed with less than 24 hours notice, the patient will be charged a $25 cancellation fee for the first missed appointment, a $50 cancellation fee for the second missed appointment and then will be dismissed from the practice.*** **Should the patient change their mind for whatever reason during treatment, the patient will be responsible for all costs incurred including lab fees and related costs.**

I have read, understood and agree to the Office Financial Policy stated above.

_____ _____

Patient/Guardian Signature Date

(updated 2/25/2020 Dr.A)

Please flip page over and sign bottom of back page

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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. If you sign a Consent Form, we may use and disclose your medical records only for each of the following purposes: treatment, payment and healthcare operations.

- Treatment means providing, coordinating, or managing healthcare and related services by one or more healthcare providers. An example of this would include teeth cleaning services.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Healthcare operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example would be an internal quality assessment review.
- We may also create and distribute de-identified health information by removing all references to individually identifiable information.
- We may, without prior consent, use or disclose protected health information to carry out treatment, payment, or healthcare operations in the following circumstances:
- In emergency treatment situations, if we attempt to obtain such consent as soon as reasonably practicable after the delivery of such treatment;
- If we are required by law to treat you, and we attempt to obtain such consent but are unable to contain such consent; or
- If we attempt to obtain your consent but are unable to do so due to substantial barriers to communicating with you, and we determine that, in our professional judgment, your consent to receive treatment is clearly inferred from the circumstances.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. This notice is effective as of October 17, 2002 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office. You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

I do NOT authorize any information to be discussed with any family members or friends. I authorize information about treatment or appointments to be discussed with the following person(s): _____

I have read and I understand the above information.

_____ _____

Patient/Guardian Signature Date