

Welcome and thank you for choosing us for your dental care. Please fill out the following

forms in ink. If you have any questions, please do not hesitate to ask us for assistance.

This information is necessary for our records and is considered CONFIDENTIAL.

**PATIENT REGISTRATION INFORMATION**

First Name: Last Name: Middle Initial:

Gender: Male Female

Date of Birth: / / Age:

Address: Apt

City State Zip

Home Phone: ( ) Cell Phone: ( )

Email:

Preferred Contact Method: Home Phone Cell Phone Email

Emergency Contact Name: Relation:

Emergency Contact Phone Number: ( )

How did you hear about our office? (circle one)

Friend/Family ‘Drove By’ Yelp Google Facebook Boone HS

Yellow Pages Emergency Room Internet Search Another Dentist

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have dental insurance? Yes\* No *(no problem! Feel free to ask us for a fee schedule)*

*Our office is out-of-network with all dental insurance plans, but can provide you with a coded claim form upon request.*

***Registration continues on next page***

**PATIENT DENTAL AND MEDICAL HISTORY**

What is your reason for today's visit?

Do you have a comprehensive care dentist that you see on a regular basis?

No Yes ***If yes, name***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was your last dental visit and what was done then? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Women Only:** Are you pregnant or think you might be pregnant? Yes No

If yes, how many weeks?

Are you nursing? Yes No

Are you taking birth control pills? Yes No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex

Local Anesthetics Sulfa Drugs

Please list any other allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you do not believe that you have any allergies, check here: No Known Drug Allergies

Do you take a blood thinner? (Examples are: Heparin, Warfarin, Plavix, Coumadin, Pradaxa, Xarelto)

No Yes ***If yes, name***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever or are you taking bisphosphonate drugs? (Examples are: Fosamax, Boniva, Actonel,

Reclast, Prolia, Zometa, Alendronate) No Yes ***If yes, name***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any medicine(s) that you are taking, including non-prescription medication(s), if any:

***If you have a list feel free to give it to the receptionist to scan and save some time.***

Medication How Often Do You Take This? Why Do You Take This Medication?

**YES NO YES NO**

HAVE THERE BEEN ANY CHANGES IN ARE YOU UNDER THE CARE OF

YOUR GENERAL HEALTH WITHIN THE PHYSICIAN? If yes, please provide

PAST YEAR? Physician’s name and phone number:

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HAVE YOU EVER BEEN HOSPITALIZED

FOR ANY SURGICAL OPERATION OR

HAVE YOU EVER HAD IV SEDATION SERIOUS ILLNESS? If yes, please explain:

BEFORE? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HAVE YOU HAD ANY ABNORMAL

BLEEDING? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HAVE YOU EVER REQUIRED A BLOOD

TRANSFUSION? HAVE YOU EVER TAKEN FEN-PHEN/

If yes, please explain: REDUX (weight loss drug from the 1980’s)

DO YOU USE CONTROLLED

DO YOU USE TOBACCO? SUBSTANCES?

DO YOU HAVE A PERSISTENT COUGH OR DO YOU HAVE A DISEASE, CONDITION,

SORE THROAT NOT ASSOCIATED WITH A OR PROBLEM NOT LISTED YOU THINK I

KNOWN ILLNESS (LASTING MORE THAN SHOULD KNOW ABOUT? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3 WEEKS)?

**PLEASE CHECK YES OR NO. DO NOT DRAW A STRAIGHT-LINE DOWN.**

**HAVE YOU EVER BEEN DIAGNOSED WITH OR HAD ANY OF THE FOLLOWING?**

**YES NO YES NO**

RHEUMATIC HEART DISEASE DIABETES

SCARLET FEVER AIDS OR HIV INFECTION

HEART DEFECT OR HEAR MURMUR THYROID PROBLEMS

HEART TROUBLE/ANGINA ARTHRITIS OR RHEUMATISM

ARTIFICIAL HEART VALVE JOINT REPLACEMENT OR IMPLANT

HEMOPHILIA STOMACH ULCER

PACEMAKER KIDNEY TROUBLE

HEART SURGERY TUBERCULOSIS

HIGH/LOW BLOOD PRESSURE CHEMOTHERAPY (CANCER, LEUKEMIA)

CONGENITAL HEART PROBLEM RADIATION THERAPY

SWELLING OF FEET, HANDS, ANKLES MITRAL VALVE PROLAPSE

HEPATITIS A, B, C, OR LIVER DISEASE EPILEPSY OR SEIZURES

STROKE ANEMIA

SINUS TROUBLE GLAUCOMA

ARTIFICIAL JOINT TUMORS

ASTHMA OR HAY FEVER MENTAL HEALTH CARE

RENAL DIALYSIS CHEMICAL DEPENDENCY

HYPOGLYCEMIA STOMACH/INTENSTINAL DISEASE

CORTISONE TREATMENT SICKLE CELL DISEASE

SLEEP APNEA GASTRIC BYPASS

**PATIENT SIGNATURE DENTIST SIGNATURE**

**Orlando Dentures & Implants, Inc. - *Terms and Conditions***

● I certify that I have read and understand the above information regarding my past medical and dental history and, 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 health.

● I consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anesthetic and the use of radiographs as indicated for proper dental care. I understand that the use of anesthetic agents embodies a certain risk and the refusal of diagnostic aids such as radiographs during the examination process will release the Doctor of responsibility for early diagnosis.

● As a condition of treatment by this office, I understand financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. Full payment is due at time of treatment unless other arrangements have been approved. I understand that I will be informed of any treatment changes that occur and I will assume responsibility for fees associated with all procedures and all costs incurred in the collection of those fees. A $30.00 fee will be assessed for any checks returned as Non-Sufficient Funds (NSF).

● A non-refundable deposit of $100 per hour for extraction/implant appointments will be required at the time of scheduling to hold your appointment. The deposit will be applied towards the balance due the day of treatment. We ask for at least 24 hours’ notice as a courtesy, if you will need to cancel or reschedule. We are more than happy to reschedule your appointment and apply your deposit towards a future appointment if you give at least 24 hours’ notice. If you reschedule or cancel less than 24 hours prior to your appointment time your deposit is non-refundable and a new deposit will be required to book any future appointment.

**By signing below, I certify that I have read, understand, and agree to the above conditions of treatment and agree to their content.**

**X Date**

Signature of Patient, Parent if Minor or Guardian

If you are not the Patient, please indicate your relationship to the patient:

Parent Legal Guardian Other (explain)

**Orlando Dentures & Implants, Inc. - *Privacy Practices/HIPAA* – Consent**

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize Orlando Dentures & Implants, Inc. to use and disclose my protected health information to carry out:

● Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)

● Obtaining payment from third party payers (e.g. my insurance company)

● The day-to-day healthcare operations of your Orlando Dentures & Implants, Inc.

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 right under HIPAA before signing this consent. I understand that a complete copy of the Orlando Dentures & Implants *Notice of Privacy Practices* is also posted in the reception room and that a complete copy can be obtained from the receptionist at any time. I understand that Orlando Dentures & Implants, Inc. reserves the right to change the terms of this notice from time to time and that I may contact Orlando Dentures $ Implants, Inc. 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 healthcare operations, but that Orlando Dentures & Implants, Inc. is not required to agree to these requested restrictions. However, if Orlando Dentures & Implants, Inc. does agree, Orlando Dentures & Implants, Inc. is then bound to comply with this restriction.

I understand that I may revoke this consent in writing at any time and all future disclosures will then cease. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

**By signing below, I certify that I have read and understand the above consent and have been given the opportunity to as any questions that I may have.**

**X Date**

Signature of Patient, Parent if Minor or Guardian

If you are not the Patient, please indicate your relationship to the patient:

Parent Legal Guardian Other (explain)