Varner Family Dentistry

Patient Registration (Section must be completed yearly)

So that we can provide you with the best possible care, please answer all questions.
Your answers are for our records and will be considered confidential.

Patient's Yearly Review
(Please initial and date once a year when updating.)
Initial: _____
Date: ____|____|____

Initial: _____
Date: ____|____|____

Initial: _____
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Initial: _____
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Initial: _____
Date: ____|____|____

Initial: _____
Date: ____|____|____

First Name: Middle: Last Name:

What name do you prefer to go by? Date of Birth:

Email: Social Security #:

Address: Street City, State, Zip:

Home Phone: ( ) Cell Phone & Carrier: ( ) Text /Leave Message? ☐ Yes ☐ No

Employer/School & Grade: Phone: ( ) Leave Message? ☐ Yes ☐ No

Emergency Contact: Relationship: Phone: ( ) Leave Message? ☐ Yes ☐ No

Address: Street City, State, Zip:

How did you hear about our office? (Name of referrer, postcard, internet, yellow pages, etc.)

What is the reason for today's visit?

What are your goals for your dental care?

☐ I Would like to keep my teeth all my life.
☐ I would like to eat and drink comfortably.
☐ I would like to improve the appearance of my smile.
☐ Other:

Authorization for Use or Disclosure of Patient Information (If you want information released to another person other than yourself or parent/ guardian.)

I, Patient's Name, hereby authorize **Varner Family Dentistry** to make the use and disclosure of the patient information as described below. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA Privacy regulations.

□ Appointments/ Treatment Plan (Includes x-rays) □ Financial Information □ All dental/medical information □ Other: _____

The following person(s) may receive this patient information:

Name: Phone: ( )

Name: Phone: ( )

Authorization expires on the following date or when the following event occurs:

Expiration Date: Other:

I understand that I may revoke this authorization at any time by the following the directions in the Notice of Privacy Practices.
I understand that my revocation must be in writing and received by the dental practice's Privacy Official at 3612 W. Southern Hills Blvd. Suite # 1, Rogers, AR 72758.
I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan or eligibility for benefits.

Patient/ Guardian Signature: Date:

Release

I authorize the doctor or other dentists or health-care professionals (interdisciplinary team members) to perform diagnostic procedures and treatment as may be necessary for proper dentofacial care.
I authorize release of any information concerning my (or my child's) health care for advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits
I authorize release of any information concerning my (or my child's) health care for advice and treatment to interdisciplinary team members.
I authorize the taking of photographs, radiographs and other diagnostic records before, during and after treatment, and to the use of the same by the doctor or interdisciplinary team members in scientific presentations or scientific literature
Insurance Authorization Statement:
I hereby authorize payment directly to the Dental Office for the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs and dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on the patient registration and the medical & dental histories is correct to the best of my knowledge.

Patient/ Guardian Signature: Date:

Patient/ Guardian Signature: Date:

Varner Family Dentistry

Patient Registration (Section must be completed yearly)

So that we can provide you with the best possible care, please answer all questions. Your answers are for our records and will be considered confidential.

Patient's Yearly Review (continued)

Initial: _____
Date: ____|____|____

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Initial: _____
Date: ____|____|____

Primary Dental Insurance

Address: Street City, State, Zip:

Subscriber/Policy holder: Relationship to Patient:

Date of Birth: Social Security #: - -

Employer: Effective Date:

Group #: Identification #:

Insurance Company: Phone: ( )

Secondary Dental Insurance (If applicable)

Address: Street City, State, Zip:

Subscriber/Policy holder: Relationship to Patient:

Date of Birth: Social Security #: - -

Employer: Effective Date:

Group #: Identification #:

Insurance Company: Phone: ( )

Parent/Guardian Responsible for Account (if minor-child)

Full Name: **Relationship:**

Address: Street **City, State, Zip:**

Date of Birth: **Social Security #:** - -

Employer: **Years at Employer:**

Employer Address: **Work Phone: ( )**

Authorization to Accompany Minor Child for Dental Treatment (section must be completed)

The Federal Government has mandated that Dentist and Clinics must protect the private health information of patients. Varner Family Dentistry realized that sometimes parents or legal guardians cannot accompany their child to a dental appointment. The purpose of this form is to allow someone other than the parent or legal guardian to accompany a child being treated at Varner Family Dentistry. It must be understood that private health information may be disclosed during treatment.

Name:	Age:	Relationship:
Name:	Age:	Relationship:
Name:	Age:	Relationship:
Name:	Age:	Relationship:

The authorization may be amended or revoked at any time given written notice.

By my signature below, I hereby authorize the listed individual(s) to accompany my child, in my absence, for treatment at Varner Family Dentistry. Furthermore, I understand that private health information about my child may be disclosed to these individuals(s) during treatment.

Parent/ Guardian Signature: Date:

Varner Family Dentistry

Dental History (Section must be completed yearly)

So that we can provide you with the best possible care, please answer all questions. Your answers are for our records only and will be considered confidential.

Doctor, RDH, & RDA Review

Who was your previous dentist? Why did you leave?

What did you like most about your last dentist?

Do you have any dental concerns?

Are any of your teeth currently sensitive? ☐ Yes ☐ No

If yes, are they sensitive to: ☐ Hot ☐ Cold ☐ Sweets ☐ Pressure

Have you ever had a problem with:

Have you noticed any mouth odors or unpleasant tastes?	☐ Yes	☐ No
Do your gums hurt or bleed?	☐ Yes	☐ No
Have you noticed any loose teeth or change in you bite?	☐ Yes	☐ No
Do you have a problem with food impacting between your teeth?	☐ Yes	☐ No
Do you clench or grind your teeth?	☐ Yes	☐ No
Do you have a history of thumb, finger, or lip sucking?	☐ Yes	☐ No
Do you have a tongue thrusting habit?	☐ Yes	☐ No

Have you ever experienced:

Clicking or popping of the Jaw?	☐ Yes	☐ No
Difficulty opening or closing your jaw?	☐ Yes	☐ No
Difficulty chewing?	☐ Yes	☐ No
Pain or soreness around your joint or ear area?	☐ Yes	☐ No
Chronic headaches or facial pain?	☐ Yes	☐ No
Wake up with tired, hurt, or ache in your jaw?	☐ Yes	☐ No

Have you ever had an injury or impact to your mouth, jaw or head? ☐ Yes ☐ No

If yes, when and how?

Do you have any missing teeth? ☐ Yes ☐ No

If yes, have they been replaced? ☐ Yes ☐ No

If yes, by what means?

☐ Fixed Bridge ☐ Removable Partial ☐ Full Denture ☐ Implant

Are you satisfied with you tooth replacement? ☐ Yes ☐ No

Have you ever had any of the following:

☐ Orthodontic Treatment ☐ Bite Adjustment ☐ Root Canal Treatment

☐ Oral Surgery ☐ Periodontal (Gum) Treatment ☐ TMJ Treatment

Have you ever had a problem associated with previous dental treatment? If yes, please explain: ☐ Yes ☐ No

Varner Family Dentistry

Medical History (Section must be completed yearly)

So that we can provide you with the best possible care, please answer all questions. Your answers are for our records only and will be considered confidential.

Preferred Pharmacy: Name Address Phone:

Doctor, RDH, RDA Review:

Primary Physician: Name Address Phone ( )

Secondary Physician Address Phone ( )

Last Medical Examination Day / Month / Year Reason:

Are you currently being treated for any conditions? If so, please list:

☐ None

Please list all prescription and non-prescription medication you are taking, including dosage:

Medication Dosage Medication Dosage

Medication Dosage Medication Dosage

Have you ever been hospitalized or had a serious illness? If yes, please explain: ☐ Yes ☐ No

(Please Circle)

Do you take antacids? Yes No Do you take Tagamet or Cimetidine? Yes No

Do you take herbal medications or dietary supplements?

Garlic Ginger Ma Huang Kava Ginko
Ginseng Ephedra St. John's Wort Valerian Other: _____

Do you consume alcoholic beverages or coffee?
If yes, how frequent?

Do you smoke or use other tobacco products?
If yes, how frequent?

(Please Circle)

Have you ever been told to take antibiotics prior to dental visits? Yes No
Do you have a pacemaker or a prosthetic heart valve? Yes No
**WOMEN: Is there a chance you are or could be pregnant? Yes No If yes, how many weeks? _____
Are you: ☐ Nursing ☐ Taking birth control

Are you allergic or sensitive ☐ **None**

☐ Aspirin
☐ Antibiotics
☐ Base Metals (Costume Jewelry)
☐ Codeine/Other Narcotics
☐ Dental Anesthetics (Shots)
☐ General Anesthetics
☐ Ibuprofen (Motrin, Nuprin)
☐ Latex
☐ Penicillin
☐ Sedatives or Sleeping pills
☐ Other: _____
☐ Other: _____

Have you ever had: ☐ **None**

☐ Autoimmune
☐ Abnormal bleeding
☐ Alcohol Abuse
☐ Allergies
☐ Anemia
☐ Angina Pectoris
☐ Arthritis
☐ Asthma
☐ Blood Transfusion
☐ Cancer
☐ Chemotherapy
☐ Chest Pain
☐ Other:_____
☐ Colitis/Crohn's
☐ Congenital Heart Defect
☐ Diabetes
☐ Difficulty Breathing
☐ Drug Abuse
☐ Epilepsy/Seizures
☐ Facial Surgery
☐ Fainting or Dizziness
☐ Blister/Canker Sores
☐ Frequent Headaches
☐ Glaucoma/Cataract
☐ HIV/AIDs
☐ Heart Valve
☐ Heart Attack
☐ Heart Murmur
☐ Heart Surgery
☐ Hepatitis A B C
☐ High ☐ Low Blood Pressure
☐ Joint Replacement:
☐ Kidney/Bladder Problems
☐ Liver Disease
☐ Lung Disease
☐ Measles
☐ Mitral Valve Prolapse
☐ Other:_____
☐ Pacemaker
☐ Psychiatric Problems
☐ Radiation Therapy
☐ Rheumatic Fever
☐ Sexually Transmitted Disease
☐ Shingles
☐ Sickle Cells Disease
☐ Sinus Problems
☐ Stroke
☐ Thyroid Problems: _____
☐ Tuberculosis
☐ Ulcers

Varner Family Dentistry

3612 W. Southern Hills Blvd., Suite 1
Rogers, AR 72758
(479)636-3121

I have been offered and/or received a copy of Varner Family Dentistry's Notice of Privacy Practices. I understand that my PHI (Protected Health Information) can and will be used for purposes of treatment and payment from both myself and/or third party. I understand that I may request a copy of the privacy policies at any time.

Print Patient Name: _____

Patient Signature: _____

Print Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date: _____

Consent to Discuss Treatment or Billing Information

I, (Patient Name) , give consent to VARNER FAMILY DENTISTRY discuss my treatment and or Billing information with the following person(s):

_____	_____	_____
Print Name	Relationship to patient	Telephone number
_____	_____	_____
Print Name	Relationship to patient	Telephone number

Patient Signature or Parent/Guardian if Under 18: _____ Date: _____

☐ Patient ☐ Parent ☐ Guardian / Other

Consent form will expire 1 year from the date of Signature, Insurance Change, or Patient reaching the age of 18.

For Office Use Only:

Please complete the following only if the acknowledgment section above has not been signed by the patient or the patient's personal representative; We made a good faith effort to obtain a written Acknowledgment of Receipt of Notice of Privacy Practices, but an acknowledgment could not be obtained because (please check one or more as appropriate):

__ The patient or the patient's personal representative refused to sign.

__ A communication barrier prevented us from obtaining an acknowledgment.

__ An emergency situation prevented us from obtaining an acknowledgment.

__ Other (please explain)

Completed by: _____ Position: _____
Staff Signature: _____ Date completed: _____

Consent form expires: _____

Varner Family Dentistry

3612 Southern Hills Blvd.
Rogers, AR 72758
(479)636-3121

Patient's Name (print): _____

Date of Birth: _____

Describe the records you wish to access:

All X-rays and Records

___ **I wish to get a copy of the requested records from my previous dental office.**

Name:

_____

Address:

_____

Phone:

_____

X **I want you to send the copy of the requested records to:**

Name: Varner Family Dentistry

Address: 3612 W. Southern Hills Blvd. Ste 1. Rogers, AR 72758

Email: info@varnerdentistry.com

Patient Signature: _____ Date: _____

Print the Name of the Personal Representative: _____

Relationship to the Patient: _____

I have the legal authority under federal and state laws to make this request on behalf of the patient identified above.

Signature of Personal Representative:

_____ Date: _____

_____

For Dental Office Use

___ Requested for access denied (attach written denial)

___ Request for access approved.

_____

Sleep Apnea Questioner

Please take a few minutes to fill out this form regarding your sleep habits and quality of the sleep you experience.

Your answers will be kept confidential. Thank you for your participation.

Patient Name: **Age:**

In general, what is the quality of your health?

☐ Outstanding ☐ Good ☐ Some chronic issues ☐ Poor

Has anyone told you that you snore loudly?

☐ Yes ☐ No

Is your snoring interrupted by pauses or choking?

☐ Yes ☐ No

Has anyone told you that you stop breathing or does your breathing pause during your sleep?

☐ Yes ☐ No

Do you wake up tired after a full night's sleep or are you tired throughout the day?

☐ Yes ☐ No

Do you have or are you being treated for sleep apnea?

☐ Yes ☐ No

Are you interested in a sleep study or sleep apnea treatment?

☐ Yes ☐ No