PATIENT REGISTRATION

FIRST NAME: ______________________________ LAST NAME: ______________________________________MIDDLE INITIAL: _______

PATIENT IS: ☐ POLICY HOLDER PREFERED NAME: _________________________________

☐ RESPONSIBLE PARTY

PATIENT INFORMATION

ADDRESS: ____ ADDRESS 2: ____

CITY, STATE, ZIP: ____

HOME PHONE: ______________________ WORK PHONE: ____________________EXT: ________ CELLULAR: _______________________

PLEASE CIRCLE:

SEX: ☐ MALE ☐ FEMALE MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED

BIRTH DATE: __________________ AGE: ______ SOCIAL SECURITY NUMBER: _____________________ DRIVERS LIC.: ________________

EMAIL: ____ ☐ I would like to receive correspondence via email.

HOW DID YOU HEAR ABOUT US? ____

EMPLOYMENT STATUS: ☐ FULL TIME ☐ PART TIME ☐ RETIRED

STUDENT STATUS: ☐ FULL TIME ☐ PART TIME

EMPLOYER ID: _____________________________

PREFERED PHARMACY: ______________________________________ PHONE NUMBER: __________________________________

CARRIER ID: ____

RESPONSIBLE PARTY (IF SOMEONE OTHER THAN PATIENT)

FIRST NAME: ______________________________ LAST NAME: ______________________________________MIDDLE INITIAL: _______

ADDRESS: ____ ADDRESS 2: ____

CITY, STATE, ZIP: ____

HOME PHONE: ______________________ WORK PHONE: ____________________EXT: ________ CELLULAR: _______________________

BIRTH DATE: ________________________ SOCIAL SECURITY NUMBER: _____________________ DRIVERS LIC.: _____________________

☐ RESPONSIBLE PARTY IS ALSO A POLICY HOLDER FOR THE PATIENT ☐ PRIMARY INS. POLICY HOLDER ☐ SECONDARY INS. HOLDER

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:____________________________________

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:____________________________________

MEDICAL HISTORY

PATIENT NAME: ____ BIRTH DATE: ____________________________

Please mark (x) to your response to indicate if you have or have had any of the following

- ☐ AIDS/HIV Positive
- ☐ Alzheimer's Disease
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Arthritis
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Breathing Problem
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Cold Sores/Fever Blisters
- ☐ Congenital Heart Disorder
- ☐ Convulsions
- ☐ Cortisone Medicine
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Easily Winded
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Fainting Spells/Dizziness
- ☐ Frequent Cough
- ☐ Frequent Diarrhea
- ☐ Frequent Headaches
- ☐ Genital Herpes
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack/Failure
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Heart Trouble/Disease
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hives or Rash
- ☐ Hypoglycemia
- ☐ Irregular Heartbeat
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Pain in Jaw Joints
- ☐ Parathyroid Disease
- ☐ Psychiatric Care
- ☐ Radiation Treatments
- ☐ Recent Weight Loss
- ☐ Renal Dialysis
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Spina Bifida
- ☐ Stomach/Intestinal Disease
- ☐ Stroke
- ☐ Swelling of Limbs
- ☐ Thyroid Disease
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors or Growths
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Yellow Jaundice

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

____

Physician Name: ___________________________ Address: _____________________________ Phone: ___________________

Have you had a serious illness, operation, or hospitalization in the past 5 years? Y or N If yes, please explain: _________________

____

Are you taking or have you recently taken any prescription or over the counter medicine(s)? Y or N If yes, please list all and why, including vitamins, natural and/or dietary supplements: ____

____

____

List All Medications or Substitutes You are ALLERGIC to:

____

____

____

____

Have you ever in the past, or are you now currently taking any medications for Osteopenia/ Osteoporosis or Bone disease? If so, please list medications: ___________

____

____

Have you ever had surgery? If so, what type?

____

____

____

____

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 the patient's) health. It is my responsibility to inform the office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN: ____ DATE: _________________

DENTAL HISTORY

PATIENT NAME: ____ BIRTH DATE: ____________________________

Please mark (x) to your response to indicate if you have or have had any of the following

Periodontal (Gum) Health
- ☐ Bleeding Swollen, Irritated Gums
- ☐ Bad Breath
- ☐ Loose, Tipped, Shifting Teeth
- ☐ Previous Perio/Gum Disease

Pain/Discomfort
- ☐ Sensitivity
  Type: ☐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
- ☐ Bad Bite
- ☐ Speech Impediment
- ☐ Mouth Breathing
- ☐ Sore Muscles
- ☐ Difficulty Opening or Closing
- ☐ Difficulty Chewing on Either Side

Comfort With Dental Treatment
- ☐ Fear (dentists, needles, drill, etc.)
- ☐ Anxiety
- ☐ Bad Dental Experiences
- ☐ Noises

Appearance
- ☐ Discolored teeth
- ☐ Worn teeth
- ☐ Misshapen 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 list family history of any conditions marked above: ____
____
____
____

On a scale of 1-10, 10 being the highest rating, rate your smile: _____
Rate where you would like to be: _____

What would you like to change about your smile?

☐ Color	☐ Bite	☐ Chipped teeth	☐ Spaces
☐ Crowding	☐ Smile makeover	☐ Missing teeth	☐ Whiter teeth

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? ______________________________________

Consent:
The undersigned hereby authorizes Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that might 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 the Patient/Legal Guardian Date Dentist

For completion by Dentist only

Additional Comments ____
____
____

Appointment information

We realize that you may have an emergency occur or unexpected changes to your schedule, but we want to ensure that we respect the time of all of our patients. If you need to cancel or reschedule your appointment, please give us at least a 24 hour notice.

If an appointment is cancelled with less than a 24 hour notice**, you will be charged an office fee of $140 payable prior to your next visit.**

Printed Name: ____

Signature: ____

Date: ____

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 ("HIPPA") is a federal program that requires that all medical records and other individual identifiable health information used or disclosed by us in an form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant rights to understand and control how your health information is used. "HIPPA" provides penalties for covered entities that misuse personal health information.

As required by "HIPPA", 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.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

> Treatment means providing, coordinating health care and related services by one or more health care 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.
>
> Health care 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 of this 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 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.
>
> This right to obtain a paper copy of this notice from us upon request.

Acknowledgement Of Receipt Of Notice Of Privacy Practices And Financial Policy

I, ____, have received a copy of this office's Notice if Privacy Practices and Financial Policies.

____
Please Print Name

____
Signature

____
Date

* You may refuse to sign this acknowledgement *

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, as required by law, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication Barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify):

____

____