

PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

IF THIS APPOINTMENT IS FOR YOU START HERE

DATE				1
LAST NAME		FIRST	M.I.	
PREFERS TO BE CALLED BY				
ADDRESS				
CITY		STATE	ZIP	
HOME PHONE NO.			FAX	
CELL		EMAIL		
BIRTHDATE	AGE	MALE	FEMALE	
MARRIED	SINGLE	DIVORCED	WIDOWED	
SOCIAL SECURITY NO.				
<hr/>				
DATE				
LAST NAME		FIRST	M.I.	
ADDRESS				
CITY		STATE	ZIP	
HOME PHONE NO.				
BIRTHDATE	AGE	MALE	FEMALE	
SCHOOL		GRADE		
SOCIAL SECURITY NO.				

IF THIS APPOINTMENT IS FOR YOUR CHILD START HERE

DATE				
LAST NAME		FIRST	M.I.	
ADDRESS				
CITY		STATE	ZIP	
HOME PHONE NO.				
BIRTHDATE	AGE	MALE	FEMALE	
SCHOOL		GRADE		
SOCIAL SECURITY NO.				

IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO

DENTAL INSURANCE		2
PRIMARY CARRIER		
INSURANCE COMPANY		
GROUP NO.		
EMPLOYER NAME		
INSURED'S NAME		
DATE OF BIRTH	RELATIONSHIP TO PATIENT	
INSURED'S I.D. NO.		
INSURED'S SOCIAL SECURITY NO.		
SECONDARY CARRIER		
INSURANCE COMPANY		
GROUP NO.		
EMPLOYER NAME		
INSURED'S NAME		
DATE OF BIRTH	RELATIONSHIP TO PATIENT	
INSURED'S I.D. NO.		
INSURED'S SOCIAL SECURITY NO.		

ACCOUNT INFORMATION		4
PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT		
NAME		
RELATIONSHIP TO PATIENT	SOCIAL SECURITY NO.	
ADDRESS		
CITY	STATE	ZIP
PHONE NO.		
YOU		
NAME		
OCCUPATION		
EMPLOYER'S NAME		
ADDRESS	CITY	
PHONE NO.	FAX NO.	
YOUR SPOUSE		
NAME		
OCCUPATION		
EMPLOYER'S NAME		
ADDRESS	CITY	
PHONE NO.	FAX NO.	

GETTING TO KNOW YOU		3
IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?		
NAME:	RELATIONSHIP:	
YOU WERE REFERRED TO US BY		
YOUR FORMER ADDRESS		
CITY	STATE	ZIP
PERSON TO CONTACT FOR EMERGENCY		
PHONE NUMBER		
ADDRESS		
CITY	STATE	ZIP
CLOSEST RELATIVE NOT LIVING WITH YOU		
PHONE NUMBER		
ADDRESS		
CITY	STATE	ZIP

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.
5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Patient's Signature _____ Date _____ Witness _____

Parent/Responsible Party's Signature _____ Relationship to Patient _____

Patient Name

MEDICAL HISTORY

Patient Account No.

Medical Alert

- 1. Physician's Name Phone ()
Have you had any medical care within the past two years?
Describe
2. Have you taken any medication or drugs during the past two years?
3. Are you currently taking any medication, drugs, pills or herbal remedies, including regular dosages of aspirin?
If yes, please list name and dosage
4. Have you ever taken prescription medications for weight loss (diet pills)?
If yes, did you take any of the following: (circle if yes) Fen-Phen Pondimen Redux Other
If yes to any of the above, did you have a medical exam for heart issues?
5. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other similar drugs?
6. Have you been a patient in the hospital during the past five years?
7. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Table with 3 columns of conditions (Heart, Chest Pain, Congenital Heart Disease, etc.) and 2 columns of Yes/No responses.

- 8. Are you aware of having an allergic (or adverse) reaction to any substance or medication?
9. Have you lost or gained more than 10 pounds in the past year?
10. Do you have or have you had any disease, condition, or problem not listed?
If yes, please list:
11. Women: Are you pregnant or think you could be pregnant? Yes Months No Nursing? Yes No
12. Do you use birth control prescriptions?

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature Date

History Review

Dentist Signature Date

Patient Name _____
 Patient Account No. _____

Medical Alert _____

DENTAL HISTORY

*Welcome! So that we may provide you with the best possible care
 please complete both sides of this medical/dental history form.
 All information is completely confidential.*

What is the reason for your visit today? _____

Date of Last Dental Visit _____ Last Dental Cleaning _____ Last Full Mouth X-rays _____

What was done at your last dental visit? _____

Previous Dentist's Name _____

Address _____ State _____ Zip _____

Telephone _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

Have you ever used or are currently using topical fluoride? Yes No

What other dental aids do you use? (Interplak, toothpick, etc.) _____

Do you have any dental problems now? Yes No

If yes, please describe: _____

Are any of your teeth sensitive to:

Hot or cold? Yes No
 Sweets? Yes No
 Biting or Chewing? Yes No
 Have you noticed any mouth odors or bad tastes? Yes No
 Do you frequently get cold sores, blisters or
 any other oral lesions? Yes No

Do your gums bleed or hurt? Yes No
 Have your parents experienced gum disease
 or tooth loss? Yes No

Have you noticed any loose teeth or change
 in your bite? Yes No

Does food tend to become caught in between
 your teeth? Yes No

If yes, where? _____

Do you:

Clench or grind your teeth while awake or asleep? Yes No
 Bite your lips or cheeks regularly? Yes No
 Hold foreign objects with your teeth?
 (pencils, pipe, pins, nails, fingernails) Yes No
 Mouth breathe while awake or asleep? Yes No
 Have tired jaws, especially in the morning? Yes No
 Snore or have any other sleeping disorders? Yes No
 Smoke/chew tobacco or use other tobacco products? Yes No

Have you ever had:

Orthodontic treatment? Yes No
 Oral Surgery? Yes No
 Periodontal treatment? Yes No
 Your teeth ground or the bite adjusted? Yes No
 A bite plate or mouth guard? Yes No
 A serious injury to the mouth or head? Yes No
 If so, please describe, including cause _____

Have you experienced:

Clicking or popping of the jaw? Yes No
 Pain? (joint, ear, side of face) Yes No
 Difficulty in opening or closing the mouth? Yes No
 Difficulty in chewing on either side of the mouth? Yes No
 Headaches, neckaches or shoulder aches? Yes No
 Sore muscles (neck, shoulders)? Yes No

Are you satisfied with your teeth's appearance?

Would you like to keep all of your teeth all of your life? Yes No

Do you feel nervous about having dental treatment? Yes No
 If so, what is your biggest concern?

Have you ever had an upsetting dental experience? Yes No
 If yes, please describe _____

Have you ever been told to take a pre-medication prior to dental treatment? Yes No

Is there anything else about having dental treatment that you would like us to know? Yes No

If yes, please describe _____

(Please complete other side)

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW YOUR PROTECTED HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE READ THIS CAREFULLY.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR OBLIGATION TO OUR PATIENTS:

We are required by federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices that are described in this Notice while it is in effect. This notice takes effect April 14, 2009, and will remain in effect until we replace it. You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION:

We use and disclose health information about you for treatment, payment, and healthcare operations. For example: Treatment: We may use or disclose your health information to a physician, dentist or other healthcare provider (such as a specialist we refer you to) providing treatment to you. Communication with other providers is key to a successful outcome of your treatment.

Payment: We submit claims to insurance carriers for your treatment electronically and disclose your health information to obtain payment for services we provide to you. We provide information to them regarding previous and current treatment. We may also tell the insurance company about future care in order to get prior approval or an estimate of your benefits.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. This includes assessment/review of our patient services, procedures, and improvement activities, evaluating the competence, qualifications and performance of our team and licensed healthcare providers, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use of the disclosures permitted by your authorization while it is in effect. Unless you give us a written authorization, we cannot use, or disclose your health information for any reason except those described in this notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so. We will disclose health information and treatment options only to parents or guardians of minor children unless you give us prior written authorization to disclose to another party.

Persons Involved in Care: We may use or disclose health information to notify, or assist in notification of (including identifying or locating) a family member, your personal representative, or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use of disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstance, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We may notify our patients via mail about new dental procedures or products we have available. We do not share names or addresses with other businesses for their marketing purposes.

SIGNATURE _____ DATE _____