Confidential Patient Registration

Today's Date_____

Patient Name

Last_____ First_____ Middle_____
Name you prefer to be called by_____Birthdate__/__/___ M___ F____
Address
Street_____apt#_____
City _____State_____Zip_____
Home Phone _____ Cell Phone_____
Work Phone _____ Email _____
Employer_____ SSN_____
How did you hear about our office? _____
Who may we thank for referring you to our office?_____
Marital Status ____Married ___Single ___Divorced ___Separated ___Widowed

If other than above, who will be responsible for patient's financial obligation for treatment?
Last_____ First_____ Middle_____
Relationship to Patient _____ SSN _____
Birthdate__/__/___ M___ F____
Street_____apt#_____
City _____State_____Zip_____
Home Phone _____ Cell Phone_____
Work Phone _____ Email _____

Name of your preferred pharmacy_____Phone Number_____

DENTAL INSURANCE INFORMATION

Name of Insurance Company_____
Member ID Number_____
Group Number _____
Insurance Carrier Address _____ Phone Number _____
Are you the subscriber? ___Yes ___No
If you are not the subscriber, please answer the following questions.

Name of Subscriber

Last_____ First_____ Middle_____
Relationship to Patient _____ SSN _____
Birthdate__/__/___ M___ F____ Contact Information
Street_____apt#_____
City _____State_____Zip_____
Home Phone _____ Cell Phone_____
Work Phone _____ Email _____

MEDICAL INSURANCE INFORMATION

Name of Insurance Company_____
Member ID Number_____
Group Number _____
Insurance Carrier Address _____ Phone Number _____
Are you the subscriber? ___Yes ___No
If you are not the subscriber, please answer the following questions.
Name of Subscriber
Last_____ First_____ Middle_____
Relationship to Patient _____ SSN_____
Birthdate __/__/___ M___ F____
Contact Information
Street_____apt#_____
City _____State_____Zip_____
Home Phone _____ Cell Phone_____
Work Phone _____ Email _____

EMERGENCY CONTACT INFORMATION

Name _____Phone_____
Email_____
Please list the name(s) of anyone you consent to share your treatment and account information with.
Name _____ Relationship_____
Name_____ Relationship_____

DENTAL HISTORY

Previous Dentist_____ How long have you been a patient? _____
How would you rate the condition of your mouth? ( ) EXCELLENT ( ) GOOD ( ) FAIR ( ) POOR
Date of most recent dental exam? _____ Date of most recent x-rays? _____
I routinely see my dentist every: ( ) 3 MO ( ) 4 MO ( ) 6 MO ( ) 12 MO ( ) Not Routinely
WHAT IS YOUR IMMEDIATE CONCERN? _____

In order for us to provide you with an exceptional quality of care, we would like to get to know you better. As providers all of the following are important to us however, we would like to know which is the most important to you?

- **Cosmetic**
- **Function**
- **Comfort**
- **Longevity**

When considering having treatment done, which of these would be of concern to you?

- **Fear**
- **Time**
- **No Trust**
- **Budget**
- **No Sense of Urgency**

What is the most important quality for you in a relationship with your doctor?_____

Are you a person that prefers a lot of detailed information or do you prefer bottom line information?
Detailed___ Bottom Line___

Are you allergic or have you had a reaction to:

a. Local anesthetics or epinephrine…….. No___ Yes___
b. Penicillin or other antibiotics …… No___ Yes___
c. Fluoride……. No___ Yes___
d. Aspirin, Ibuprofen or Tylenol ……. No___ Yes___
e. Codeine, Valium®, Hydrocodone, Oxycodone or other sedatives…… No___ Yes___
f. Latex or Metals
g. Other (please specify)_____

Have you ever had orthodontic treatment? No___ Yes___
Have you ever had jaw surgery? No___ Yes___
Do you currently wear a nightguard or a removable appliance? No___ Yes___

HEALTH HISTORY

Name _____Preferred Name_____Age_____
Name of Physician_____Date of last health care exam: _____
What was this exam for?_____

What is your estimate of your general health?

- ☐ **Excellent**
- ☐ **Good**
- ☐ **Fair**
- ☐ **Poor**

For the following questions answer yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.

	YES	NO	DETAIL
Are you currently under medical care by a physician?			
Are you in good health?			
Do you take daily medication?			
Hospitalization for illness or injury?			
Do you have high blood pressure?			
Do you have low blood pressure?			
Blood Disorders?			
Arthritis, Rehymatism or other infalmmatory disease?			
Ashtma, COPD or other lung diseases			
Abnormal bleeding from a cut?			
High Cholesterol?			
Are you taking blood thinners?			
Anemia?			
Rheumatic Fever?			
Heart Murmur or Heart Valve Defect?			
Heart Diseases?			
Epilepsy?			
Circulation problems?			
Hepatitis?			
Treated for Tuberculosis?			
Stomach trouble or Ulcers			
Kidney Disease?			
Diabetes?			Type 1____ or Type 2_____
Thyroid Disease			
Sore or enlarged lymph nodes?			

Fainting or Dizzy Spells?			
Congenital Heart Disease?			
Heart Disease, Heart Attack, Heart Surgery Angina or Stroke?			
Heart stent?			Placed when?_____
Auto-Immune Disease?			
Phsyciatric Treatment?			
H.I.V. Infection/AIDS or ARC?			
Veneral Disease			
Previous Biopsies?			
Cancer?			
Radiation or Chemotherapy?			
Do you wear contacts?			
Hearing problems?			
Are you pregnant?			
Do you smoke?			
Have you smoked in the past?			
Do you use Vape products?			
Unusual weight gain?			
Sudden weight loss?			
Are you on a diet?			
Do you have anxiety?			
Acid reflux?			
Tumor growth?			
Heart Burn?			
Do you exercise regularly?			
Tooth sensitivity?			
Problems eating or swallowing?			
Do your gums bleed when you floss?			
Have you ever suffered an injury to your face or jaw?			
Are you aware of any white patches in your mouth?			
Do you have breath problems or mouth odors?			
Do you have slow-healing mouth sores?			
Do you suffer from headaches?			
Does your jaw "pop" or "click"			
Do you experience dry mouth in the morning?			
Has your jaw ever felt locked?			
Do you grind your teeth?			
Do you snore?			
Do you suffer from sinus pain?			
Have you had nasal surgery?			
Do you have ringing in your ears?			
Do you take pre-medication for dental treatment?			
Have you ever been treated with Bisphosphante drugs such as Fosamax, Aredia, Zometa, Actonel, Boniva, Reclast or Prolia?			If so, when did treatment end?
Have you had a joint replaced?			If so, when was the surgery?_____

Please list any medications you are currently taking and dosages:_____

_____

Please list any dietary or herbal supplements you are taking, and for what purpose:

_____

Women: Are you pregnant? No___ Yes____

SLEEP APNEA SURVEY

Do you snore loudly?	**YES___ NO____**
Do you often feel tired, fatigue, or sleepy during the day?	**YES___ NO___**
Has anyone observed you stop breathing during your sleep?	**YES___ NO___**
Do you have or are you being treated for high blood pressure?	**YES___ NO____**
BMI (Body Mass Index) more than 35?	**YES___ NO____**
Age over 50 years old?	**YES___ NO___**
Neck circumference >15.75 inches?	**YES___ NO___**

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 change in my health and medication.

_____ _____

Patient Name (Print) **Date**

_____ _____

Patient Signature **Date**

Financial Agreement for Patients

Our office understands the value of having insurance benefits to use toward your dental treatment, and we are happy to assist you by courtesy filing the necessary electronic forms and supporting documents as needed to obtain payment. We ask that you provide our business team with a benefit card or any other identifying paperwork as well as the policy holder subscriber ID and birthdate. In the event of any coverage changes we appreciate notice in advance of any dental services. Most patients understand there is never a guarantee of coverage and the benefit allowable is determined at the time the claim is received and processed with your insurance company. The insurance coverage that you have is a contract between you/your employer and the insurance company therefore in the event on non-payment you as the patient are always ultimately responsible for payment of services rendered despite insurance denial. In the unlikely event that any insurance claims remain unpaid over 60 days, the claim will be closed and you will be responsible for paying our office and requesting direct insurance reimbursement.

Payment

Our office will present any out pocket dental expenses before any work is performed. Any services non-covered, copayments or non-insured will be expected to be paid in full at the time services are rendered, we do not issue billing unless there is an uncollected balance once insurance has paid your claim. **We accept Cash, Private Checks, Visa, Amex, MC and Care Credit as form of payment for services.**

Workers Comp/Third Party and Divorce Situation Patients

Our office does not participate in third party billing of any kind. In this event or circumstance we will be happy to provide an insurance claim and any needed documentation for you to file privately for direct reimbursement, we will collect payment from the patient in full at the time of service. In the event of a separation or divorce, we ask that all applicable co-payments are paid by the parent or guardian that accompanies the minor to their dental appointment at the time of service. If insurance benefits are to be filed on behalf a child or minor, please provide the necessary filing information to our business team.

Cancellation Fee

Our office requires 48 hour notice in the event of cancellation or reschedule. We understand emergency happens however we are a business that respects our patient's time and we ask the same from our patients. A fee of $100 per hour scheduled will be applied to your account in the event of repeated missed appointments.

Collection

As stated above, our office will work to make you aware of any out of pocket cost however any accounts that involve insurance are an estimate until the claim is considered and paid. Our office will issue a statement and work to communicate with you in the event of a past due balance, it is your responsibility to ensure payment is received in a timely manner. Accounts over 90 days past due without response, a "Warrant in Debt" will be filed with the court seeking collection on the account.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

I, do hereby consent and acknowledge my agreement to the terms set forth in the WRITTEN FINANCIAL POLICY FORM and any subsequent changes in the office policy after giving patient consent. I understand that this consent shall remain in force from this time forward.

_____	_____	_____
Patient Name or Responsible Guardian (Print)	Signature	Date

MEDIA RELEASE

We understand that choosing a new dentist and a dental health team can be challenging. Let us welcome you and share some insights about what we do for our patients.

"Our purpose is to help people achieve the highest level of well-being appropriate for them and, in so doing, to transform the quality of their lives."

In other words, we help you be or become as healthy as you CHOOSE. This is a major departure from the way we were trained. Instead of telling you how healthy you ought to be, we will try to help you understand your choices about dental health and then let you make a free and informed decision. In order to do this, we take photographs as a part of your new patient exam. These photographs are used to:

a. Discuss your treatment needs and wants
b. Discuss treatment options with specialists
c. Help with Insurance Claims
d. OTHER

I hereby consent for _____ to use, reproduce, exhibit or distribute (in full or in part) any photographic, video, film and or audio recording made of me or my likeness; and/or any written extraction of such recordings in which I may be included, for any purpose whatsoever, in and in any and all media now or hereafter known for illustration promotion, art, editorial, advertising, trade, or any other purpose whatsoever. I also consent to the use of any printed matter in conjunction therewith. I hereby waive any right that I may have to inspect or approve the finished product or products and the advertising copy or the other matter that may used in connection therewith or the use to which it may be applied.

I hereby release, discharge and agree to hold harmless_____ and all persons acting under its permission or authority from any liability or injury that may occur while performing or appearing in the said video, audio, or photographic production.

Name (print): _____

Signature:_____

Address:_____

City : _____ State: _____ Zip: _____

Email:_____

Phone: _____

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

Our office is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnosis, treatment, and applying for future care of treatment. It also includes billing documents for those services. *Your Health Information Rights*

The health and billing records we maintain are the physical property of the practice. You have the following rights with respect to your Protected Health Information.

1. Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office-we are not required to grant the request but we will comply with any request granted.

2. Obtain a paper copy of the Notice of Privacy Practices for Protected Health Information ("Notice") by making a request at our office.

3. Right to inspect and copy your health record and billing record. You may exercise this right by delivering the request in writing to our office using the form we provide you upon request. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. If you request copies, we may charge a small fee. If you request an alternative format, we will charge a cost based fee for providing your health information in that format.

4. Right to appeal a denial of access to your protected health information, except in certain circumstances.

5. You have the right to request that we amend your protected health information. (Your request must be in writing, and it must explain why information should be amended). The doctor is not required to make such amendments. You may file a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information.

6. Right to receive an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office using the form we provide to you upon request. An accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your

request, or disclosures made to family members or friends in the course of providing care.

7. Right to confidential communication by requesting that communication by requesting that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office using the form we provide you upon request. If you want to exercise any of the above rights, please contact the office manager in person or in writing.

Our Responsibilities

Our office is required to: * Maintain the privacy of your health information as required by law.

* Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you.

* Abide by the terms of this Notice.

* Accommodate your reasonable requests regarding methods to communicate health information with you.

* Accommodate your request for an accounting of disclosures.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice", by visiting our office and picking up a copy, or by downloading the revised copy from our website.

To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact the Office Manager. Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to the Office Manager. You also may submit a written complaint to the U.S. Department of Health and Human Services. We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from this office. We cannot, and will not retaliate against you for filing a complaint with the Secretary of Health and Human Services.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this agreement.

I have received a copy of this office's Notice of Privacy Practices.

_____ Please Print Name

_____ Signature Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of our Notice of Privacy Practices, 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)**