TIME 2:33 PM DATE 8/5/2019

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder Preferred Name:
☐ Responsible Party

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

◯ Responsible Party is also a Policy Holder for Patient ◯ Primary Insurance Policy Holder ◯ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ◯ Male ◯ Female Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed

Birth Date: Age: Soc. Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ◯ Full Time ◯ Part Time ◯ Retired

Student Status: ◯ Full Time ◯ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg.:

Section 3

Referred By:

Previous Dentist:

Emergency Contact:

Emergency Contact #:

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:

Rem. Benefits: .00 Rem. Deduct: .00

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:

Rem. Benefits: .00 Rem. Deduct: .00

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

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

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

WELCOME TO OUR DENTAL GROUP

We are happy that you have chosen our group as your dental health provider. The dentists and staff are looking forward to a long and healthful relationship with all or our patients.

Our primary concern is your oral health and dental needs; we will strive to provide you with the best quality a professional care that you desire and deserve.

In order to provide timely appointment for all patients, we ask that you please cancel an appointment which you have scheduled and that you are unable to keep, by at least 24 hours before that appointment time. This will enable us to provide that valuable time for another patient and/or an emergency. In fairness to all, a charge of $5.00 per 15 minutes of scheduled time will be billed if your appointment is not cancelled. We record the cancellations in your medical legal record and charge only the allowed amount as stipulated by your insurance coverage.

Naturally the cost of dental care is of concern to all patients. It is customary to have the patient's share or co-payment paid as the service is rendered unless special arrangements have been discussed and agreed upon by the office manager. In order to keep our fees at the lowest reasonable levels possible, we must have precise and just payment procedures. While only a small minority of our patients fall into the following category we must inform you that returned checks and balances older than 30 days may be subject to additional collection fees and late payment fee 1 1/2 % per month to any balance owed, In the event of default to pay, reasonable collection charges and/or attorney fees will be added as provided by law.

Your dental coverage is a contract between you, your employer and the Insurance Company. We are not a party of that contract. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain dental services they do not cover. No special letters or words to them will change that coverage. If you request, we will give you a good faith estimate of charges after your examination. Those estimates are subject to change if you decide on a different course of treatment and use of different materials or a biomechanical need encountered during the treatment phase. The estimate is not a guarantee of price. It is your responsibility to know your insurance coverage, not ours. There are thousands of policies and payment schedules and we cannot know precisely what you or your employer has purchased. You are personalley responsible for the entire fee for professional services rendered.

If you have any questions regarding your dental care, privacy rights, or any other needs that we should know, please feel free to speak to your dentist or the office management regarding your concerns. Remember we want to help and encourage your participation in your good oral health goals.

Thank you, and welcome to our dental group.

Patient's signature_____Date_____

Dental Group Practice Information

Notice of Privacy Practices-Effective Date: April 14,2003

This notice is required by law by the Privacy Regulations
Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA)

This notice describes how medical information about you or your child (as a patient of this practice) may be used and disclosed and how you can get access to this information. Please review it carefully.

A Full legal version of this notice is available.
If you would like a copy of the full version, please see our front office staff.

At this Dental Group we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice, get your signature, and to follow the terms of this notice. Without this notice we cannot treat you or process your insurance. This form is unalterable by law. The law permits us to use or disclose your health information to those involved in your treatment. For example, a discussion of or copy of your records may be sent to another physician or dentist that we refer you to.

We may use or disclose your health information for payment of your services. For example, we may send a report of your care to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, when you arrive we will ask you to sigh in, or one of our staff will enter your information into our computer.

We may share your information as needed with our business associates, such as our answering service or medical record storage company. We have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example, we may send newsletters or other information to you in the mail. We may call you to confirm your appointment or give you test results. If you are not home, we may leave this information on your answering machine or with the person that answers the phone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We may release some or all of your health information when law requires it.

If this practice is ever sold, your information will become the property of the new owner.

Except as described above, we will not use or disclose your health information without your prior written authorization.

You may request in writing that we not disclose your health information as described above. We will let you know if we can fulfill your request.

You have a right to know of any uses or disclosures we make with your information beyond normal uses.

As we will sometimes need to contact you, we will use whatever address or telephone number you prefer.

You have the right to transfer copies of your health information to another practice. We will mail your files for you. There will be a cost (as allowed by law) for the time and materials to copy and send your records. You have the right to see and receive a copy of your health information, with a few exceptions. You must give us a written request regarding the information you want to see. If you also want a copy of your records, we will charge you a reasonable fee for the copies as the law allow.

You have the right to request an amendment or change to your health information. You must give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the change, we will not remove nor alter earlier documents, but will add new information. You have a right to receive another copy of this notice. If we change any of the details of this notice you will be notified.

If you feel that your rights have been violated, you may file a complaint with the Department of Health and Human Services, 200 Independence Ave. S.W., Room 509F, Washington, DC-20201. You will not be retaliated against for filing a complaint. Before filing a complaint, please contact our office and ask for our Manager and Privacy Officer.

(Over for other required information and signature)