Patient Registration

First Name: _____ Last Name: _____

Preferred Name: _____ Middle Initial: _____

Address: _____

City: _____ ST: _____ Zip: _____

Primary Phone: _____ Secondary Phone: _____

Email: _____ Driver's License Number: _____

Birthday: _____ Age: _____ SSN: _____

SEX: M ☐ F ☐ Employment Status: F/T ☐ P/T ☐ Retired ☐ Student Status: F/T: ☐ P/T: ☐

Insured/Responsible Party (If different from patient)

First Name: _____ Last Name: _____

Preferred Name: _____ Middle Initial: _____

Address: _____

City: _____ ST: _____ Zip: _____

Primary Phone: _____ Secondary Phone: _____

Email: _____ Drivers License Number: _____

Birthday: _____ Age: _____ SSN: _____

Relationship to Insured: ☐ Self: ☐ Spouse: ☐ Child: ☐ Other: _____

Primary Insurance Information:

Employer: _____ Insurance Company: _____

Insurance Company Address: _____

City, ST, Zip: _____

Insurance Phone: _____

Patient information

Are there particular issues or services you would like to discuss with the doctor?

- ☐ Toothache/Pain
- ☐ Removal of Wisdom Teeth
- ☐ Bridge/Partial/Denture
- ☐ Gum Bleeding/Pain
- ☐ Chipped or Cracked Teeth
- ☐ Clear Correct /Braces
- ☐ Implants

Additional Information/Comments

_____

_____

_____

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_____

Patient Name

Date

Who can we thank for your visit with us today?

- ☐ Drive/Walk by
- ☐ Insurance Company
- ☐ Transfer from Another Office
- ☐ Patient Referral_____
- ☐ Online Search
- ☐ Mailer
- ☐ Staff
- ☐ Other _____

☐ **Interested in 3rd party financing**

Special offers

- ☐ **I opt in** to receive special offers via email or text message
- ☐ **I opt out** of receiving special offers via email or text message

Notice of privacy practices

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 legal duty

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in the Notice while it is in effect. This Notice takes effect April 14, 2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we retain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

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 or other healthcare provider providing treatment to you.

Payment: we may use and disclose your health information to obtain payment for services we provide to you.

Healthcare operations: we may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, 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 or disclosures permitted by your authorization while it was 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 int he 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 our agree that we may do so.

Persons involved in care: we may use or disclose health information to notify, or assist in the 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 or disclosure of your health information, we ill provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, 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 will not use your health information for marketing communications without your written authorization.

Required by law: we may use or disclose your health information when we are required to do so by law.

Abuse or neglect: we may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence, or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety of the health or safety of others.

National security: we may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment reminders: we may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

Patient rights

Access: you have the right to look at or get copies of your health information, with limited exceptions. 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. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you requested copies, we have the right to charge you $0.05 for each page, $15.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure accounting: you have the right to receive a list of instances in which we or our business associates disclosed your heath information for purposes other than treatment, payment, healthcare operations, and certain other activities for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: you have the right to request that we place additional restrictions on our use of disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement except in an emergency.

Alternative communication: you have the right to request that we communicate with your about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location and provide a satisfactory explanation of how payments will be handled under the alternative means or location you request.

Amendment: you have the right to request that we amend your health information. Your request must be in writing and it must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic notice: if you receive this Notice on our web site or by electronic main (email), you are entitled to receive this Notice in written form.

Questions and complaints

If you are concerned that we may have violated your privacy rights or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

If you want more information about our privacy practices or have questions or concerns, please contact our office.

Use and disclosure of health information consent form

Please read the following statement carefully.

By signing this form, you will consent to our use and disclosure of your protected health information, including x-rays, photographs, and videos, to carry out treatment, payment activities, clinical review and training, and healthcare operations.

Notice of privacy practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment practices, clinical review and training, and healthcare operations, of the uses and disclosures we may make of your protected healthcare operations, and of other important matters about your protected health information. A copy of this notice is available upon request. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice at any time by contacting our office.

Right to revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation of this Consent. Your revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation. We may decline to treat you or continue treating you if you revoke this Consent.

Consent

By signing this consent form, you have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, clinical review and training, and healthcare operations.

Signature _____ **Date** _____

Medical history

Patient Name _____ 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?
☐ No ☐ Yes _____

Have you ever been hospitalized or had a major operation?
☐ No ☐ Yes _____

Have you ever had a serious head or neck injury?
☐ No ☐ Yes _____

Are you taking any medications, pills, or drugs?
☐ No ☐ Yes _____

Do you take, or have you taken Phen-Fen or Redux?
☐ No ☐ Yes _____

Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates?
☐ No ☐ Yes _____

Are you on a special diet?
☐ No ☐ Yes _____

Do you use tobacco?
☐ No ☐ Yes _____

Do you use a controlled substance?
☐ No ☐ Yes _____

_____
Additional Information/Comments

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

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

Are you allergic to any of these:

☐ Aspirin
☐ Penicillin
☐ Codeine
☐ Acrylic
☐ Metal
☐ Latex
☐ Sulfa Drugs
☐ Other _____

Women, are you:

☐ Pregnant or Trying to Get Pregnant
☐ Nursing
☐ Taking Oral Contraceptives

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.

_____
Patient Name

_____ _____

Financial policy

We are privileged you have chosen us as your dental care provider. We are committed to providing you and your family with quality patient care. The following is a statement of our Financial Policy, which you need to understand prior to treatment. If you have any questions, please feel free to ask.

Full payment is due at the time of service. We accept cash and most major credit cards. Also, we reserve the right to charge for appointments canceled or broken without 24 hours advance notice.

Regarding insurance

Your insurance policy is a contract between you and your insurance company. We have no control over their decisions and the amount they decide to pay. However, as a courtesy to our patients, we will file your primary insurance claims for you.

Before treatment, we will verify your coverage and calculate your deductible and copayments as accurately as possible. Please understand that all treatment plans given are only an estimate based on the information your insurance company provides. All deductibles and copayments are due the day the treatment is rendered.

Please be aware that your insurance company does not guarantee payment over the phone. We will not know the exact amount they will pay until they respond to the claim.

REGARDLESS OF WHAT YOUR INSURANCE COMPANY PAYS, YOU REMAIN FULLY RESPONSIBLE FOR PAYMENT OF YOUR BILL. Once a payment is received on your claim, we will send you a bill of any remaining balance on your account.

At our discretion, any unpaid balance after 90 days will be sent to collections at which the patient is responsible for any fees associated with the collection for the balance.

I have read and understand the above Financial Policy. By signing below, I acknowledge responsibility and agree to the terms above.

Signature _____ **Date** _____

Broken appointment policy

Reserved appointment time in any dental office is limited and valuable. It is extremely important that all patients honor their reserved dental appointments. Failure to do so deprives our other patients from receiving needed dental care in a timely fashion.

So that the dentist, our staff, and our patients will not be penalized by those who fail to keep scheduled appointments, our office policy stipulates that failure to give sufficient warning to keep a scheduled appointment (24 hours advance notification), will result in a $50.00 fee being charged. That charge, which is in accordance with out dental office's broken policy for all of our patients, is to be paid within 30 days to prevent collection procedures. The patient/parent/legal guardian is responsible for the payment of the charge.

Please feel free to discuss this and other policies with our staff. Do not hesitate to call our office if you have any questions.

Signature **Date**

MEDCIAL INFORMATION RELASE FORM

NAME: _____ DATE: _____

RELEASE OF INFORMATION

I _____authorize the release of information including the diagnosis, records and examination rendered to me and claims information. This information may be released to the following:

SPOUSE: _____

CHILDREN: _____

OTHER: _____

☐ INFORMATION IS NOT TO BE RELEASED TO ANYONE.

This RELEASE OF INFORMATION will remain in effect until terminated by me in writing.

SIGNATURE: _____ DATE: _____

Oral Cancer Screening Consent Form

Oral Cancer foundation has reported that one American dies every hour from oral cancer. Late detection is the most prominent cause for the increased number of incidence and increased mortality rate. As with most cancers, age is the primary risk factor for oral cancer. Tobacco and alcohol use are other major predisposing risk factors, but more than 25% of oral cancer victims have no such lifestyle risk factors.

Oral cancer risk by patient profile is as follows:

1. Patients ages 18-39 (sexually active patients 16-18/HPV). Increased risk
2. Patients age 40 and older, tobacco users (any age, within 10 years). High risk
3. Patients age 40 and older; tobacco and/or alcohol use; previous history of oral cancer. Highest risk

Our office has recently incorporated special oral cancer screening device, *Goccles*, which utilizes specific range of light wavelength to detect various intraoral lesions such as dysplasia or oral cancer. We have noticed that using the device greatly improves the ability to identify any suspicious areas at the early stage without any pain nor surgery.

We charge $25 for this enhanced examination with *Goccles* per screening.

( ) YES. I authorize the clinician to perform *Goccles* oral cancer screening along with the standard oral cancer examination. I accept financial responsibility for this enhanced examination.

( ) NO. I decline the *Goccles* enhanced oral cancer screening at this time.

Signature: _____ Date: _____

Print Name: _____

Let's Work Together To Achieve Good Oral Health

Please take a moment and complete the sections below so we can have meaningful discussions with you today and help you reach your goals.

Most oral disease can be prevented. Since oral health is closely linked to overall health, your answers to these questions will help us work together to improve your health and maintain your lifestyle.

- What are your long term goals for your oral health?

_____

- Please share any oral health questions or concerns you have today.

_____

- Has anything changed in your oral health since your last visit?

_____

- What would you like our dental team to accomplish for you today?

_____

For Children

Any cavities in the past year?	❑ Yes	❑ No
Any family history of cavities?	❑ Yes	❑ No
Beverage besides water used for sleep?	❑ Yes	❑ No
Between-meal candy, sugared snacks, crackers or cereal? (Greater than three times daily)	❑ Yes	❑ No
Are teeth brushed less than twice daily and for less than two minutes?	❑ Yes	❑ No

For Adults

Any cavities in the past 1-3 years?	❑ Yes	❑ No
Between-meal candy, sodas or snacks? (Greater than three times daily)	❑ Yes	❑ No
Daily dry mouth symptoms?	❑ Yes	❑ No
Food stuck in or between teeth following eating?	❑ Yes	❑ No
Are teeth brushed less than twice daily and for less than two minutes?	❑ Yes	❑ No