DENTAL REGISTRATION AND HISTORY

PATIENT	INF	OR	MATION	3	DEN	TAL INSURAN	CE	
	D-4-		140			f41-!10		
Date						for this account?		
Patient			Rel	ationship	to Patie	ent		
Address			Ins	urance C	0			
		9.84	Gro	oup#				
City State Zip			Zip					
Sex: □ M □ F Age Birthdate				Is patient covered by additional insurance? ☐ Yes ☐ No				
□ Single □ Married □ Widowed □ Separated □ Divorced			d □ Divorced Sut	Subscriber's Name				
Patient SS#			Birt	thdate _		SS#		
Occupation				ationship	to Patie	ent		100
Employer				urance C	0.			
Employer Address			1 40			ND RELEASE	-	-
Employer Phone			l, th	e undersig	gned certi	fy that I (or my dependent) have ins		
Spouse's Name	1 191		with	-		and a	assign dire	ectly 1
Birthdate	SS#	#	othe	Dr all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially				
Occupation				responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits.				
Spouse's Employer			lau	thorize the	use of this	s signature on all insurance submission	s.	
				esponsible F	arty Ciana	hura		_
Whom may we thank for refer	ring you?		ne	sponsible r	arty Signa	ture		
			Re	elationship		Date		7
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Home	Y, CONTA	/ork FOI	Best ti Specify someone who does no Relatio Work/	me to react the first transfer of the first	your house No No No No No	Loose teeth or broken filings Mouth breathing Mouth pain, brushing Orthodontic treatment Pain around ear	☐ Yes☐ Yes☐ Yes☐ Yes☐ Yes☐ Yes☐ Yes☐ Yes	
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Home E-Mail N CASE OF EMERGENCE Name Home Phone DENTAL Reason for today's visit Former Dentist City/State Date of last dental visit Date of last dental X-rays Check "Yes" or "No" where in	Y, CONTA	Ork	Best ti Specify someone who does no Relatio Work/ Work/ Burning sensation on tongue Chew on one side of mouth Cigarette, pipe, or cigar smoking Clicking or popping jaw Dry mouth Fingernail biting Food collection between the teeth	me to react the ingression of	your house h	Loose teeth or broken filings Mouth breathing Mouth pain, brushing Orthodontic treatment Pain around ear Periodontal treatment Sensitivity to cold Sensitivity to heat Sensitivity to sweets	Yes	
Home E-Mail IN CASE OF EMERGENCE Name Home Phone DENTAL Reason for today's visit City/State Date of last dental visit Date of last dental X-rays Check "Yes" or "No" where in that apply:	HIST	rOF	Best ti Specify someone who does no Relatio Work/ Burning sensation on tongue Chew on one side of mouth Cigarette, pipe, or cigar smoking Clicking or popping jaw Dry mouth Fingernail biting Food collection between the teeth Foreign objects	me to react the ingred of the	your house he	Loose teeth or broken filings Mouth breathing Mouth pain, brushing Orthodontic treatment Pain around ear Periodontal treatment Sensitivity to cold Sensitivity to heat Sensitivity to sweets Sensitivity when biting	Yes	
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Physician's Name					Date of last visit		
Place a mark on "Yes" or "No	" to indicate i	f you have had any of the	e following:				
AIDS	□ Yes □ I	lo Emphysema	□ Yes	□ No	Psychiatric Care	☐ Yes	ON
Alzheimers	☐ Yes ☐ N		☐ Yes	□ No	Radiation Treatment	☐ Yes	
Anemia	□ Yes □ N		s 🗅 Yes	□ No	Respiratory Disease	☐ Yes	ON
Arthritis, Rheumatism	☐ Yes ☐ N	lo Glaucoma	☐ Yes	□ No	Rheumatic Fever	☐ Yes	
Artificial Heart Valves	☐ Yes ☐ N	lo Headaches	☐ Yes	□ No	Scarlet Fever	☐ Yes	01
Artificial Joints	☐ Yes ☐ N		☐ Yes		Shortness of Breath		
Asthma	☐ Yes ☐ N				Sinus Trouble	☐ Yes	01
Back Problems	☐ Yes ☐ N	lo Hepatitis (Type) 🖵 Yes	□ No	Skin Rash	☐ Yes	01
Bleeding abnormally, with	☐ Yes ☐ I		Yes	□ No	Special Diet		
extraction or surgery		High Blood Pressur			Stroke		
Blood Disease	☐ Yes ☐ I		☐ Yes		Swelling of Feet or Ankles	☐ Yes	
Cancer	The state of the s		□ Yes		Swollen Neck Glands	☐ Yes	01
Chemical Dependency		lo Jaw Pain	☐ Yes		Thyroid Problems	☐ Yes	
Chemotherapy	☐ Yes ☐ I	lo Kidney Disease			Tonsillitis	☐ Yes	
Circulatory Problems	☐ Yes ☐ I	lo Liver Disease	☐ Yes	□ No	Tuberculosis	☐ Yes	01
Congenital Heart Lesions	☐ Yes ☐ I				Tumor or growth on	☐ Yes	01
Cortisone Treatments	☐ Yes ☐ I	lo Mitral Valve Prolaps	se 🗆 Yes		head or neck		
Cough, persistent or bloody		No Nervous Problems	☐ Yes			☐ Yes	
Diabetes	☐ Yes ☐ I	lo Pacemaker	☐ Yes	□ No	Venereal Disease	☐ Yes	
ist medications you are curr	CATIO	INS	☐ Aspirin		ALLERGIES		
List iniculcations you are curr	cittly taking.			c (Cloor			
				☐ Barbiturates (Sleeping pills)			
			_ Codeine		Other		
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Financial Agreement

Our goal is to provide the highest quality of dental care possible and to have clear communication of our financial policy.

ALL ACCOUNTS ARE DUE AND PAYABLE AT TIME OF SERVICE. If a procedure requires multiple appointments, arrangements may be made to separate the payment among each of the appointments.

Patients with insurance: The PATIENT is responsible for the ESTIMATED non-covered portion, procedures and/or deductibles at the time of the service. If the insurance company does not pay after 90 days, we will bill you directly for the full balance.

Parents not accompanying their child to an appointment must make PRIOR arrangements for payment (cash, check or credit card authorization).

Parents accompanying their children are financially responsible for payment.

There is a \$35.00 processing charge for non-sufficient funds or returned checks.

Records can be viewed at any time. There is a nominal charge for release or copies of records.

Because instruments, chairs, and personnel are reserved exclusively for your appointment, we kindly ask that you provide at least 48 hours notice if you are unable to make it.

Pay	/men	t 0	atio	n a.
ray	men	r or	οιτο	ns:

- 1. Cash
- 2. Check
- 3. Debit Card
- 4. MasterCard
- 5. Visa
- 6. Discover

I,	, agree to these financial terms.
Signature	Date



HIPPA Compliance Patient Consent Form

Our Notice of Privacy provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your right under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, of so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPPA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not by retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- 2. The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not agree to these restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- 5. The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to cor May we leave a message on your answering mach May we discuss your medical condition with any n If yes, please name the members allowed:	Yes Yes Yes	No No No	
This consent was signed by:			
(PLEASE PRIN	NT NAME)		
Signature:	DATE:		
Witness:	DATE:		