

The Dental Center at Thornton Plaza

NEW PATIENT REGISTRATION

PATIENT INFORMATION

PATIENT NAME: Last _____ First _____ Middle Initial ____
SEX: M F BIRTHDATE _____ AGE _____
SOCIAL SECURITY # _____

RESPONSIBLE PARTY INFORMATION

NAME: Last _____ First _____ Middle Initial ____
RESIDENCE: Street _____ Apt # _____
CITY _____ STATE _____ ZIP _____
MAILING ADDRESS: Street _____ Apt # _____
CITY _____ STATE _____ ZIP _____
HOME PHONE _____ CELL PHONE _____
WORK PHONE _____ DATE OF BIRTH _____
SOCIAL SECURITY # _____
EMPLOYER _____

PRIMARY DENTAL INSURANCE INFORMATION

POLICYHOLDER'S NAME: Last _____ First _____
POLICYHOLDER'S DATE OF BIRTH _____ SSN/ID # _____
EMPLOYER _____
INSURANCE COMPANY _____
INSURANCE CO. ADDRESS _____
GROUP # _____

SECONDARY DENTAL INSURANCE INFORMATION

POLICYHOLDER'S NAME: Last _____ First _____
POLICYHOLDER'S DATE OF BIRTH _____ SSN/ID# _____
EMPLOYER _____
INSURANCE COMPANY _____
INSURANCE CO. ADDRESS _____
GROUP # _____

SIGNATURE _____ DATE _____

NEW PATIENT HEALTH HISTORY FORM

DENTAL HISTORY

HOW LONG SINCE your last cleaning? _____

Last COMPLETE dental exam: Date _____

Date of Last FULL MOUTH XRAYS: _____

Are you having PROBLEMS now? _____

Explain _____

Have you had any PERIODONTAL (GUM) treatments? _____

Name of PREVIOUS dentist _____

City _____ State _____

MEDICAL HISTORY

Do you have any CURRENT HEALTH PROBLEMS? _____

Are you under a PHYSICIAN'S CARE now? (for what?) _____

What MEDICATIONS are you currently taking? _____

Have you ever taken Fen-Phen/Redux? _____

Are you PREGNANT? _____

Do you use cigars/cigarettes, pipe or chewing tobacco? (circle) _____

PLEASE CIRCLE ANY OF THE FOLLOWING YOU HAVE HAD, OR NOW HAVE:

- | | | |
|-------------------------|------------------------------------|-----------------------------|
| AIDS/HIV Pos. | Eating Disorder | Nervous problems |
| HPV | Epilepsy | Pacemaker/heart surgery |
| Acid Reflux | Fainting | Psychiatric Care |
| Anaphylaxis | Food Allergies | Rapid weight loss/gain |
| Arthritis | Glaucoma | Radiation Treatment |
| Artificial heart valves | Headaches | Respiratory disease |
| Artificial joints | Heart murmur | Rheumatic/scarlet fever |
| Asthma | Heart problems (describe)
_____ | Shingles |
| Anemia | Hemophilia (Abnormal bleeding) | Shortness of breath |
| Atopic (allergy prone) | Herpes | Skin rash |
| Back problems | Hepatitis | Stroke |
| Blood disease | Hip or Knee Replacement | Surgical Implant |
| Cholesterol | High blood pressure | Swelling of feet/ankles |
| Cancer | Jaw pain | Thyroid disease/malfunction |
| Chemical dependency | Kidney disease/malfunction | Tobacco habit |
| Chemotherapy | Liver disease | Tonsilitis |
| Circulatory problems | Material allergies | Tuberculosis |
| Cortisone treatments | Mitral valve prolapse | Ulcer/Colitis |
| Cough up blood | | 1 Diabetes |
| Other _____ | | |

ARE YOU ALLERGIC TO OR HAVE YOU REACTED TO ANY OF THE FOLLOWING?

Aspirin Local Anesthetic Erythromycin Latex (balloons, gloves, etc)

Nitrous Oxide Codeine Penicillin Sulfa

Other _____

SIGNATURE _____ DATE _____

CONSENT FOR TREATMENT & FINANCIAL RESPONSIBILITIES

The undersigned hereby authorizes the Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the Doctor to perform any and all forms of treatment, prescribe medication, and any therapy that may be indicated. I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor, and that I am still fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to the Doctor. Any and all payments received by the Doctor from my insurance coverage will be credited to my account. I further understand that a finance charge will be added to any overdue balance.

DENTAL OFFICE RESPONSIBILITIES:

1. Complete your insurance claim forms and submit them to your carrier within 24 hours of treatment.
2. Accept direct payment from your insurance carrier and keep track of claims paid and balances still owed.
3. If necessary, refile your insurance a second time within a 60 day period at your request.

PATIENT RESPONSIBILITIES:

1. To pay fees or copays not covered by your plan at the time of treatment.
2. To provide our office with the necessary information regarding your insurance to allow claims to be filed correctly, including a **current** copy of your dental insurance card.
3. To pay any account balance not paid by your insurance company after 2 billing attempts.
4. If you fail to pay your account as agreed and are referred to a collection agency, you shall be responsible for any reasonable attorney fees, costs of collection, and court costs incurred in efforts to enforce this agreement.

Thank you for choosing our office. We will do all we can to help you obtain the benefits appropriate for your particular insurance plan. If you need to set up a payment plan to assist with the costs not covered by your insurance, please feel free to discuss those options with the Front Office. Please sign below, authorizing us to submit claims on your behalf to your carrier and that you will comply with the above.

I hereby authorize payment directly to The Dental Center of the insurance benefits otherwise payable to me. I understand that I am ultimately responsible for all costs of dental care and treatment. I grant the right to the dentist to release my dental histories and other information about my dental treatment to third party payers.

SIGNATURE

DATE

HIPAA PRIVACY POLICY

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- **Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment, directly and indirectly.**
- **Obtain payment from third-party payers.**
- **Conduct normal healthcare operations such as quality assessment and physician certifications.**

Your ***Notice of Privacy Practices*** contains a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its ***Notice of Privacy Practices*** from time to time and that I may contact this organization at any time at the address above to obtain a copy of the ***Notice of Privacy Practices***.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient Name (please print) _____

Signature _____

Date _____