***The Dental Center Patient Registration Form***

**Patient Information**

PATIENT NAME: Last \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M.I. \_\_\_\_\_\_\_\_\_

SEX: M F DATE OF BIRTH \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MARITAL STATUS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ APT # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ZIP \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SOCIAL SECURITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EMAIL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMERG. CONTACT: Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Responsible Party Information (if different from above)**

NAME: Last \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M.I. \_\_\_\_\_\_\_\_\_

HOME PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CELL PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WORK PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMPLOYER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SOCIAL SECURITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Dental Insurance Information**

POLICYHOLDER’S NAME: Last \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SOCIAL SECURITY/ID NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMPLOYER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ INSURANCE COMPANY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INSURANCE COMPANY PHONE #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GRP. #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Secondary Dental Insurance Information**

POLICYHOLDER’S NAME: Last \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SOCIAL SECURITY/ID NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMPLOYER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ INSURANCE COMPANY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INSURANCE COMPANY PHONE #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GRP. #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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 the 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 RESPONSIBILITES**

 1. Complete your insurance claim forms and submit to your carrier within 24 hours of treatment.

 2. Accept direct payment from your insurance carrier and keep track of claims paid and balances owed.

 3. If necessary, refile your insurance a second time within a 60 day period at your request.

**PATIENT RESPOSIBILITIES**

 1. Pay fees or copays not covered by your plan **at the time of service**.

 2. 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. Pay any account balance not paid by your insurance.

 4. Failing to pay account as agreed, you shall be responsible for any reasonable attorney fees, costs of collection, and court costs incurred in efforts to enforce agreement.

**I AGREE THAT THE ABOVE INFORMATION IS TRUE AND TO THE BEST OF MY KNOWLEDGE. I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE DENTAL CENTER OF THE DENTAL BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT I AM ULTIMATLEY RESPOSIBLE FOR ALL COSTS OF DENTAL CARE AND TREATMENT.**

**Signature of Patient/Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Health History**

**Dental History**

How long since your last cleaning? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last dental exam? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of your last full mouth x-rays? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are you having any dental problems now? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of previous dentist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any periodontal (gum) treatments? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History**

Physicians Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you under the care of a physician at this time? **YES NO** If yes, for what condition? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last physical examination: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are you allergic/ had any adverse reaction to any medicines, drugs, local anesthetics, LATEX or other substances? **YES NO** List **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 Treatment in past 6 months? **YES** **NO** If yes, for what condition? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been hospitalized or have a serious illness (including MRSA infection) within the last 5 years? **YES NO**

If yes, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you now or have you ever smoked cigarettes, marijuana or used tobacco products? **YES NO**

Number of packs \_\_\_\_\_\_\_\_ Number of years \_\_\_\_\_\_\_\_ QUIT? **YES NO** Year Quit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had surgery or x-ray treatment for a tumor, growth or other conditions of your head or neck? **YES NO**

 If yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you taking or have you ever taken any medications, (example below), either orally or by injection, for osteoporosis, osteopenia or bone loss due to aging OR lung cancer, breast cancer, prostate cancer, colorectal cancer, wet macular degeneration, Paget’s disease, or multiple myeloma? **YES NO**

 Examples: Fosamax (alendronate); Boniva (ibandronate); Actonel (risedronate); Reclast yearly injection (zoledronic acid); Aredia (pamidronate); Zometa (zoledronic acid); Bonefos (clodronate); Avastine (bevacizumab); Erbitux (cetuximab); Herceptin (trastuzumab); Fen-phen/Redux.

Please list any premedication, medications, pills, or drugs with dosage which you are taking both prescription/nonprescription.

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| **Medication** | **Dosage** | **Reason Prescribed** |
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Do you have or have you had any of the following disease/problems?

\*Abnormal bleeding,bruise or history **YES NO \***Artificial/Prosthetic heart valves **YES NO**

of transfusion. Taking asprin/blood thinner. Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Angina/Chest pain, shortness of breath **YES NO** \*Alcohol abuse (rehabilitation) **YES NO**

\*Arteriosclerosis/Coronary occlusion **YES NO** \*AIDS/HIV/Herpes **YES NO**

\*Acid Reflux **YES NO** \*Anaphylaxis **YES NO**

\*Anemia **YES NO** \*Arthritis **YES NO**

\*Artificial Heart valves **YES NO** \*Artificial/Prosthetic Joints **YES NO**

\*Asthma **YES NO** \*Back Problems **YES NO**

\*Blood Disease **YES NO** \*Congenital Heart Disease **YES NO**

\*Congestive Heart Failure **YES NO** \*Coronary Artery/other heart disease **YES NO**

\*Cancer/Chemo/Radiation Therapy **YES NO** \*Cholesterol **YES NO**

\*Chemical Dependency **YES NO** \*Circulator Problems **YES NO**

\*Cortisone Treatments **YES NO** \*High blood Pressure **YES NO**

\*Drug Abuse (cocaine,cocaine,crack **YES NO \***Emotional/mental health disorder (anxiety, **YES NO**

Methamphetamines) drug rehabilitation depression, bipolar disorder)

\*Epilepsy/seizures/convulsions **YES NO \***Eating Disorder **YES NO**

\*Food allergies **YES NO \***Glaucoma **YES NO**

\*Dental anxiety **YES NO \***Hives, itching ,or skin rash **YES NO**

\*Heart attack **YES NO** \*Heart surgery **YES NO**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Headaches **YES NO** \*Heart murmur **YES NO**

\*Heart Problems **YES NO** \*Hepatitis **YES NO**

Describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ A\_\_\_\_\_ B\_\_\_\_\_ C\_\_\_\_\_

\*Hemophilia (abnormal bleeding) **YES NO** \*Jaw Pain **YES NO**

\*Hip/Knee Replacement **YES NO** \*Diabetes **YES NO**

 Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Type: I\_\_\_\_\_ II\_\_\_\_\_

\*Kidney/Renal Disease **YES NO** \*Infective Endocarditis (heart infection) **YES NO**

\*Implanted cardio-defibrillator **YES NO** \*Immune suppression or deficiency **YES NO**

\*Lung/respiratory condition **YES NO** \*Liver Disease **YES NO**

(asthma, bronchitis, emphysema) (Hepatitis, Jaundice, Cirrhosis)

\*Mitral valve prolapsed **YES NO** \*Nervous Problems **YES NO**

\*Pacemaker/Heart surgery **YES NO \***Psychiatric Care **YES NO**

\*Respiratory Disease **YES NO** \*Sexually transmitted disease(s) **YES NO**

\*Stomach ulcers **YES NO** \*Shortness of breath **YES NO**

\* Valve damage following heart transplant **YES NO** \*Surgical Implant **YES NO**

\*Thyroid disease/malfunction **YES NO** \*Tuberculosis **YES NO**

\*Ulcer/colitis **YES NO** \*Shingles **YES NO**

\*Stroke **YES NO** \*Material allergies **YES NO**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any other diseases, conditions, or problems not listed above? **YES NO**

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**WOMEN ONLY:**

Are you pregnant? **YES NO** Expected due date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently breast feeding? **YES NO** Birthcontrol? **YES NO**

**Any item on the medical history with a “YES” response could require a Medical Clearance from a licensed physician. The Medical Clearance must include the physician’s name, address, and phone number.**

**\*\*I certify that I have read and understand the above. I acknowledge that I have answered these questions accurately and completely. I will not hold The Dental Center responsible for any action taken or not taken because of errors I made when completing this form.**

**Patient Printed Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Patient/Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Witness\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| **Update Date** | **Patient Signature** | **Witness Signature** |
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**HIPPA Privacy Policy for The Dental Center**

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), 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 The Dental Center had the right to change its **Notice of Privacy Practices** from time to time and that I may contact The Dental Center at any time 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 restricted restrictions, but if you agree, then you are bound to abide by such restrictions.

**Family members allowed access my private information:**

|  |  |
| --- | --- |
| **Name** | **Date of Birth** |
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Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_