

**PATIENT REGISTRATION**

**First Name:** \_\_\_\_\_ **Last Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Age:** \_\_\_\_\_  
**Address:** \_\_\_\_\_ **City, State, Zip:** \_\_\_\_\_  
**Home Phone:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_ **Ext:** \_\_\_\_\_ **Cell:** \_\_\_\_\_  
**Sex:**  Male  Female **Marital Status:**  Married  Single  Divorced  Separated  Widowed  
**SS#:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ **E-mail:** \_\_\_\_\_  I would like correspondence via e-mail  
 Patient is also Responsible Party  Patient is Primary Insurance Holder  Patient is Secondary Insurance Holder  
**Employer:** \_\_\_\_\_ **Employment Status:**  Full Time  Part Time  Retired  
**Student Status:**  Full Time  Part Time **Name of School:** \_\_\_\_\_  
**Emergency Contact Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_  
**Responsible Party (if someone other than the patient):**  
**First Name:** \_\_\_\_\_ **Last Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **SS#** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
**Address:** \_\_\_\_\_ **City, State, Zip:** \_\_\_\_\_  
**Home Phone:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_ **Ext:** \_\_\_\_\_ **Cell:** \_\_\_\_\_  
**How did you hear about our office?**  Internet  Neighborhood Mailer  Family/Friend  Other \_\_\_\_\_  
**Name of person or office referring you to our practice:** \_\_\_\_\_

**Are you under a physician's care now?**  Yes  No **Doctor's Name:** \_\_\_\_\_  
**Have you ever been hospitalized or had a major operation?**  Yes  No \_\_\_\_\_  
**Have you ever had a serious head or neck injury?**  Yes  No \_\_\_\_\_  
**List any medications you are taking:** \_\_\_\_\_  
**Do you take, or have you taken, Phen-Fen or Redux?**  Yes  No **Do you use tobacco?**  Yes  No **Do you use controlled substances?**  Yes  No  
**Women:**  Pregnant/Trying to get pregnant?  Nursing?  Taking oral contraceptives?

**Are you allergic to any of the following?**  
 Aspirin  Penicillin  Codeine  Acrylic  Metal  Latex  Local Anesthetics  Other \_\_\_\_\_

- Do you have, or have you had, any of the following?
- |  |  |   |  |   |
|--|--|---|--|---|
| <input type="checkbox"/> AIDS/HIV Positive       | <input type="checkbox"/> Breathing Problem         | <input type="checkbox"/> Drug Addictions      | <input type="checkbox"/> Heart Trouble/Disease   | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Anaphylaxis             | <input type="checkbox"/> Cancer/Leukemia           | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Hemophilia              | <input type="checkbox"/> Renal Dialysis   |
| <input type="checkbox"/> Angina/Chest Pains      | <input type="checkbox"/> Chemotherapy              | <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Hepatitis A, B, or C    | <input type="checkbox"/> Rheumatic Fever* |
| <input type="checkbox"/> Arthritis/Gout          | <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Herpes                  | <input type="checkbox"/> Stroke           |
| <input type="checkbox"/> Artificial Heart Valve* | <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Heart Murmur*        | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Tuberculosis     |
| <input type="checkbox"/> Artificial Joint*       | <input type="checkbox"/> Diabetes/Hypoglycemia     | <input type="checkbox"/> Heart Pace Maker*    | <input type="checkbox"/> Mitral Valve Prolapse*  | <input type="checkbox"/> Venereal Disease |

\*Condition may require medication

**Do you now have or have you ever had any serious illness not listed above?**  Yes  No **If yes, please explain below.**  
\_\_\_\_\_

**Primary Insurance Information:**  
**Name of Insured:** \_\_\_\_\_ **Relationship to Patient**  Self  Spouse  Child  Other  
**Insured SS#:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ **Insured DOB:** \_\_\_\_\_  
**Insured Employer:** \_\_\_\_\_ **City, ST** \_\_\_\_\_  
**Ins. Company:** \_\_\_\_\_

**Secondary Insurance – we will be happy to assist you in filing your secondary insurance.**

## Financial Policy/Consent for Services/HIPPA Policy

As a condition of your treatment by this office, financial arrangements must be made in advance. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

**INSURANCE:** All dental services furnished are charged directly to the patient and he or she is personally responsible for payment. Patients who have dental insurance understand that any co-payment or deductible is due at the time of treatment. This dental office cannot render services on the assumption that our charges will be paid by an insurance company. We cannot force an insurance company to pay any claim since the benefits are purchased by you or your employer. As a courtesy, this office will file insurance claims and will credit any such collections to the patient's account. However, if the insurance carrier has not made payment within 60 days of treatment, the patient or responsible party must settle the balance immediately. This office will then assist you in seeking reimbursement from your insurance company.

**FINANCIAL:** A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

A \$20 service fee will be charged for all returned checks.

The fee estimate listed for dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed, unless objected to by me in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our notice before signing the Consent. The terms of our notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The patient understands that:

Protected health information may be disclosed or used for treatment, payment, or health care operations.

The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.

The Practice reserves the right to change the Notice of Privacy Practices.

The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.

The patient may revoke this Consent in writing at any time and all future disclosures will then cease.

The Practice may then condition treatment upon the execution of this consent.

Signature indicates that I have read the above conditions of treatment and payment and agree to their content.

- The questions on this form have been accurately answered to the best of my knowledge.
- I authorize release of necessary information to the insurance company.
- I authorize payment of benefits directly to the provider.
- I have received a copy of the HIPPA Notice of Privacy Practices.

Relationship to Patient: \_\_\_\_\_ / \_\_\_\_\_  
Signature of patient/parent or guardian/guarantor Date