

# PATIENT REGISTRATION

(PLEASE PRINT)

Date \_\_\_\_\_ Home Phone \_\_\_\_\_

Patient \_\_\_\_\_  
Last Name First Name Initial Preferred Name

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex:  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_  Single  Married  Widowed  Separated  Divorced

Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Spouse's Birthdate \_\_\_\_\_

Spouse Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_

Who is responsible for this account? \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Social Security # \_\_\_\_\_ Spouse's Social Security # \_\_\_\_\_

Name of Primary Dental Insurance Company \_\_\_\_\_ Group Number \_\_\_\_\_

Do you have a Secondary Insurance? \_\_\_\_\_

In case of emergency, who should be notified? \_\_\_\_\_ Phone \_\_\_\_\_

Name of friend or relative not currently residing with you \_\_\_\_\_ Phone \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

# MEDICAL HISTORY

PATIENT NAME \_\_\_\_\_ Birth 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?  Yes  No If yes, please explain: \_\_\_\_\_
- Have you ever been hospitalized or had a major operation?  Yes  No If yes, please explain: \_\_\_\_\_
- Have you ever had a serious head or neck injury?  Yes  No If yes, please explain: \_\_\_\_\_
- Are you taking any medications, pills, or drugs?  Yes  No If yes, please explain: \_\_\_\_\_
- Do you take, or have you taken, Phen-Fen or Redux?  Yes  No \_\_\_\_\_
- Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?  Yes  No \_\_\_\_\_
- Are you on a special diet?  Yes  No
- Do you use tobacco?  Yes  No
- Do you use controlled substances?  Yes  No

Women: Are you pregnant/Trying to get pregnant?  Yes  No Taking oral contraceptives?  Yes  No Nursing?  Yes  No

- Are you allergic to any of the following?
- Aspirin  Penicillin  Codeine  Local Anesthetics  Acrylic  Metal  Latex  Sulfa drugs
- Other If yes, please explain: \_\_\_\_\_

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

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

Have you ever had any serious illness not listed above?  Yes  No

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_

# Authorization to Release Health Information

Expires upon one time release

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**Patient Information:**

Name of Patient \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

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I authorize the practice below to release my health information:

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

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Please forward/release my health information to:

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

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The information below is provided at the request of the patient. (Describe PHI needed)

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

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**This authorization shall be in effect until the information has been forwarded as requested.**

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**Patient Information**

I understand that my treatment will not be conditioned on signing this authorization and that I have the right to refuse to sign this authorization. *I understand that information disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.*

I understand that I have the right to revoke this authorization by sending a written notification to the address below and that a revocation is not effective if the information has already been disclosed but will be effective going forward.

I understand that I have the right to inspect or copy the protected health information as described in this document. I can do this by written notification to \_\_\_\_\_

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

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Signature of Patient or Personal Representative \_\_\_\_\_ Date \_\_\_\_\_

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Description of Personal Representative's Authority (attach necessary documentation)

# Authorization for Release of Information

Name of Patient \_\_\_\_\_ Date of Birth \_\_\_\_\_

\_\_\_\_\_ is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

<b>Entity to Receive Information.</b> Check each person/entity that you approve to receive information.	<b>Description of information to be released.</b> Check each that can be given to person/entity on the left in the same section.
<input type="checkbox"/> Voice Mail	<input type="checkbox"/> Results of lab tests/x-rays <input type="checkbox"/> Other _____
<input type="checkbox"/> Spouse	<input type="checkbox"/> Financial <input type="checkbox"/> Medical as follows: _____
<input type="checkbox"/> Parent (provide name) _____	<input type="checkbox"/> Financial <input type="checkbox"/> Medical as follows: _____
<input type="checkbox"/> Other (provide name) _____ _____	<input type="checkbox"/> Financial <input type="checkbox"/> Medical as follows _____

**Patient Information**

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

*I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.*

\_\_\_\_\_  
 Signature of Patient or Personal Representative

\_\_\_\_\_  
 Description of Personal Representative's Authority (attach necessary documentation)

Date \_\_\_\_\_

**Dr. Brandon Aron, DMD**  
**1626 West Innes Street**  
**Salisbury, NC 28144**  
**(704) 639-9577**

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**CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION\_**

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**Section A: Patient Giving Consent**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

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**Section B: To the Patient—please read the following statements carefully.**

**Purposes of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and health care 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 activities, and health care operations of the uses and disclosures we make of your protected health information and of other important matters about your protected health information. A copy of our Notice accompanies this consent. 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 of Privacy Practices including any revisions of our Notice at any time by contacting:

Contact Person: Dr. Brandon Aron

Telephone: 704-639-9577

Fax: 704-639-9137

Address: Ketner Center, 1626 West Innes Street, Salisbury, NC 28144

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we receive your revocation and that we may continue treating you if you revoke this Consent.

**OVER**

I, \_\_\_\_\_, have had full opportunity to read and consider the contents of this Consent form and the 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 and health care operations.

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

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**Salisbury Dental Center  
Dr. Brandon Aron, DMD  
1626 West Innes Street  
Salisbury, NC 28144  
(704) 639-9577**

Office Policies

Welcome to our practice! Thank you for choosing us to help treat your dental needs. We understand that dental treatment can be costly and anxiety provoking. We want to begin and maintain a beneficial and healthy relationship with you and your entire dental needs.

Our office operates by appointments only in order to serve you efficiently and thoroughly. We feel an appointment is a reservation of our time as well as yours. However, if you are more than fifteen minutes late we may have to reschedule your appointment. Please keep in mind that dental emergencies do occur and from time to time we may run behind. If we are behind, please let us know if rescheduling your appointment would be more beneficial than waiting.

As with most businesses, all fees are due at the time services are rendered. We **do not** set up any payment plans. As a courtesy to you we will file your primary insurance once. **Applicable deductible and estimated amounts that are not covered by your insurance are due at the time the services are rendered.**

You are responsible for all amounts not covered by your insurance company. If your insurance company is taking an unreasonable amount of time processing your dental claim, there is little we can do to expedite your claim since we have no relationship with your insurance company. You pay the premiums so therefore they are responsible to you.

Our office accepts Checks, Visa, Mastercard, Discover and of course Cash. There is a twenty-five dollar service charge for all returned checks. **If your account becomes delinquent, it will be turned over to the credit bureau with a 25% collection fee.**

Patient/Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_