Patient Registration

Name:____ ______________________
Last First Middle Nickname

Street Address: ______________________________/________________________________
Street City State Zip

Mailing Address: _____________________________/________________________________
Street City State Zip

Birthdate: ______/______/_________ SSN:_______-______-_________ Male ☐ Female ☐
Month Day Year

Home phone: ____________________ Work: __________________ ext:______

Cell: __________________________ email:____

Preferred contact number: Home ☐ Cell ☐ Work ☐

Employer or School:__________________________________ Position or Grade: __________________

Employer Address: ____

Spouse's Name:___________________________________ Spouse's Work phone: _____________________

Birthdate: ______/______/_________ SSN:_______-______-_________
Month Day Year

Emergency contact:___________________________ Emergency phone:____________________

Whom or what may we thank for referring you to our office? ____

^^

Primary Insurance ___________________________ **Secondary Insurance** ___________________________

____ ____
Member ID Group# Member ID Group #

Policy Holder: ______________ Birthdate:_________ Policy Holder: ______________ Birthdate:_________

Relationship: _______________ Employer:________ Relationship: _______________ Employer:________

I hereby authorize payment directly to my doctor's office of the group insurance benefits otherwise payable to me. I understand that I am responsible FOR ALL COSTS of dental treatment, regardless of any dental benefits. I hereby authorize my doctor's office to perform such diagnostic and therapeutic procedures as may be necessary for proper dental care.

I certify that all of the above information is correct.

____ ___________________________
Signature Date

PATIENT INFORMATION

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

DENTAL HEALTH HISTORY

	Yes	No
Are you apprehensive about dental treatment?	☐	☐
Have you had problems with previous dental treatment?	☐	☐
Do you gag easily?	☐	☐
Do you wear dentures?	☐	☐
Does food catch between your teeth?	☐	☐
Do you have difficulty in chewing your food?	☐	☐
Do you chew on only one side of your mouth?	☐	☐
Do you avoid brushing any part of your mouth because of pain?	☐	☐
Do your gums bleed easily?	☐	☐
Do your gums bleed when you floss?	☐	☐
Do your gums feel swollen or tender?	☐	☐
Have you ever noticed slow-healing sores in or about your mouth?	☐	☐
Are your teeth sensitive?	☐	☐
Do you feel twinges of pain when your teeth come in contact with:		
Hot foods or liquids?	☐	☐
Cold foods or liquids?	☐	☐
Sours?	☐	☐
Sweets?	☐	☐
Do you take fluoride supplements?	☐	☐
Are you dissatisfied with the appearance of your teeth?	☐	☐
Do you prefer to save your teeth?	☐	☐
Do you want complete dental care?	☐	☐

	Yes	No
How often do you brush? ____		
How often do you floss? ____		
Does your jaw make noise so that it bothers you or others?	☐	☐
Do you clench or grind your jaws frequently?	☐	☐
Do your jaws ever feel tired?	☐	☐
Does your jaw get stuck so that you can't open freely?	☐	☐
Does it hurt when you chew or open wide to take a bite?	☐	☐
Do you have earaches or pain in front of the ears?	☐	☐
Do you have any jaw symptoms or headaches upon awaking in the morning?	☐	☐
Does jaw pain or discomfort affect your appetite, sleep, daily routine, or other activities?	☐	☐
Do you find jaw pain or discomfort extremely frustrating or depressing?	☐	☐
Do you take medications or pills for pain or discomfort (pain relievers, muscle relaxants, antidepressants)?	☐	☐
Do you have a temporomandibular (jaw) disorder (TMD)?	☐	☐
Do you have pain in the face, cheeks, jaws, joints, throat, or temples?	☐	☐
Are you unable to open your mouth as far as you want?	☐	☐
Are you aware of an uncomfortable bite?	☐	☐
Have you had a blow to the jaw (trauma)?	☐	☐
Are you a habitual gum chewer or pipe smoker?	☐	☐

MEDICAL HEALTH HISTORY:

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

	Yes	No
Heart Problems	☐	☐
Chest pain	☐	☐
Shortness of breath	☐	☐
Blood pressure problem	☐	☐
Heart murmur	☐	☐
Heart valve problem	☐	☐
Taking heart medication	☐	☐
Rheumatic fever	☐	☐
Pacemaker	☐	☐
Artificial heart valve	☐	☐
Blood Problems	☐	☐
Easy bruising	☐	☐
Frequent nosebleeds	☐	☐
Abnormal bleeding	☐	☐
Blood disease (anemia)	☐	☐
Ever require a blood transfusion?	☐	☐
Allergy Problems	☐	☐
Hay fever	☐	☐
Sinus problems	☐	☐
Skin rashes	☐	☐
Taking allergy medication	☐	☐
Asthma	☐	☐
Intestinal Problems	☐	☐
Ulcers	☐	☐
Weight gain or loss	☐	☐
Special diet	☐	☐
Constipation/Diarrhea	☐	☐
Kidney or bladder problems	☐	☐
Bone or Joint Problems	☐	☐
Arthritis	☐	☐
Back or neck pain	☐	☐
Joint replacement (e.g., total hip, pins, or implants)	☐	☐
Fainting Spells, Seizures, or Epilepsy	☐	☐
Stroke(s)	☐	☐
Frequent or severe headaches	☐	☐
Thyroid problems	☐	☐
Persistent cough or swollen glands	☐	☐
Premedication required by physician	☐	☐
Cancer/Tumor	☐	☐

Are you allergic, or have you reacted adversely, to any of the following?

	Yes	No
Local anesthetics ("Novocaine")	☐	☐
Penicillin or other antibiotics	☐	☐
Sulfa drugs	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐
Aspirin, Acetaminophen, or Ibuprofen	☐	☐
Codeine, Demerol, or other narcotics	☐	☐
Reaction to metals	☐	☐
Latex or rubber dam	☐	☐
Other		

Notes: ____________________

	Yes	No
Diabetes	☐	☐
Urinate more than 6 times a day	☐	☐
Thirsty or mouth is dry much of the time	☐	☐
Family history of diabetes	☐	☐
Tuberculosis or other respiratory disease	☐	☐
Do you drink alcohol? If so, how much?	☐	☐
Do you smoke? If so, how much?	☐	☐
Hepatitis, jaundice, or liver trouble	☐	☐
Herpes or other STD	☐	☐
HIV-positive/AIDS	☐	☐
Glaucoma	☐	☐
Do you wear contact lenses?	☐	☐
History of head injury?	☐	☐
Epilepsy or other neurological disease?	☐	☐
History of alcohol or drug abuse?	☐	☐

Do you have any disease, condition, or problem not listed previously that you feel we should know about?
If so, please describe:

During the past 12 months, have you taken any of the following?

	Yes	No
	☐	☐
Antibiotics or sulfa drugs		
Anticoagulants (e.g., Coumadin)		
High blood pressure medicine		
Tranquilizers		
Insulin, Orinase, or similar drug		
Aspirin		
Digitalis or drugs for heart trouble		
Nitroglycerin		
Cortisone (steroids)		
Natural remedies	☐	☐
Nonprescription drug/supplements		
Other		

Women	**Yes**	**No**
Are you taking contraceptives or other hormones?	☐	☐
Are you pregnant? If so, expected delivery date:	☐	☐
Are you nursing?	☐	☐
Have you reached menopause?	☐	☐
If so, do you have any symptoms?		

Notes: ____________________

Patient/Parent Signature: ____________________

Date: ____________________

Dentist's Initial: ____________________

Dental Care Design Financial Policies

We feel strongly that our patients deserve the best care possible. In an effort to provide you with the highest quality dental experience, we have adopted the following financial policy. We hope providing you with this information; we can prevent misunderstandings and facilitate discussions about financial and insurance matters.

- We ask that you **pay in full** at each visit. If you have insurance, we require that you pay your patient portion (the treatment costs which your insurance does not cover) in full at each visit.

- For your convenience we accept cash, debit cards, and major credit cards (AMEX, Visa, MC, and Discover). We charge $35 for checks returned to us due to closed accounts or insufficient funds.

- Your appointment is reserved just for you and no one else. **Two business days notice is required to reschedule or cancel appointments**; therefore if you fail to keep your appointment or cancel without two business days notice, a $50 fee will be assessed to your account.

- **PATIENTS WITH INSURANCE**: Please remember that your insurance contract is between you and your insurance company. If your insurance provider informs us of any benefits that you are entitled to, we will advise you of the same. Any oral representations we make in good faith to you concerning your insurance are not binding on us and will not in any way be considered a modification of this contract. Many plans cover a certain percentage of fees or pay a fixed allowance for certain procedures as determined by the insurance company. You should be aware that different insurance plans vary greatly in their level of coverage, depending usually on how much your employer paid for the plan. Please be familiar with the benefits provided by your plan.

We will bill your insurance as a courtesy to you, but we cannot guarantee your benefits. Therefore, ultimate responsibility for payment of all account balances lies with you, the patient. We will bill only those insurance companies for which you provide written information to us prior to the treatment given. Any unpaid insurance claims over 60 days will become the financial responsibility of the patient.

- Requests for duplication of records (x-rays and/or chart documentation) must be made in writing. A fee of $25 will be charged for the duplication.

This information sheet is the full and final agreement between you and this office regarding our financial policies and may not be modified without written agreement by you and this office.

I AUTHORIZE INSURANCE BENEFITS TO BE PAID DIRECTLY TO THE DOCTOR PROVIDING THE DENTAL CARE. I ALSO GIVE PERMISSION FOR THE DOCTOR TO RELEASE INFORMATION NEEDED IN ORDER TO PROCESS THE CLAIM. **I AGREE THAT I AM FINANCIALLY RESPONSIBLE FOR ALL BALANCES DUE REGARDLESS OF ANY INSURANCE BENEFITS.**

Signature:____

Printed Name:______________________________________

Date:__________________

Acknowledgement of Receipt of Notice of Privacy Policies

I have received a copy of Dental Care Design's Notice of Privacy Policies.

____ ______________________

Signature Date

Consent for Use of Personal Health Information

This form authorizes us to use your protected health information (PHI) for the purposes of healthcare operations, treatment and payment activities. **This form does not allow us to disclose your PHI to unauthorized persons outside our office without your permission.**

You may disclose my healthcare information to:

Name ____ Relationship ______________________

Name ____ Relationship ______________________

Before signing, please read our Notice of Privacy Policies to gain a clear understanding of how we may use and disclose your PHI.

Patient's Consent

I have read your Notice of Privacy Policies and I consent to your use of my PHI for the purposes of healthcare operations, treatment and payment activities.

____ ________________

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:

DENTAL CARE DESIGN
Notice of Privacy Policies

The information provided below illustrates the manner your protected health information could be accessed and released and what you need to know about this process. This important document should be reviewed thoroughly. Managing the privacy of your protected health information is extremely important to Dental Care Design.

Legal Responsibilities of Dental Care Design: As mandated by Federal and State legal requirements your protected health information must be protected. As part of these regulations we are required to ensure you are aware of privacy policies, legal duties and your rights to your protected health information. This notice of privacy policies, outlined below, will be in effect for the duration and must be followed by our practice. This notice will be in effect until it is replaced and becomes effective January 1, 2003.

We reserve the right to modify our privacy policies and the terms of this notice at any time, and will make such modifications within the guidelines of the law. We reserve the right to make the modifications effective for all protected health information that we maintain, including protected health information we created or received before the changes were made. Changing this notice will precede all significant modifications.

PROTECTED HEALTH INFORMATION USE AND DISCLOSURE: Information regarding your health may be used and disclosed for the purpose of treatment, payment and other healthcare operations.

Treatment: Use and disclosure of your protected health information may be provided to a physician or other healthcare provider providing treatment to you.

Payment: Your protected health information may be used and disclosed to obtain payment for services we provided to you.

Healthcare Processes: We may use and disclose your protected healthcare information in relations with our healthcare process. These processes include an assessment, improvement activities, reviewing the competence or qualifications of healthcare professionals, provider performances and evaluating practitioner, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: At any time you may provide in writing your authorization for use and disclosure of your protected health information for any purpose. You may choose to revoke your written permission at any time. The revocation must be in writing. If you revoke your written authorization it will not affect any use or disclosure prior to the revocation.

Your protected health care information may be used and disclosed to you, as described in the patient rights section of this notice. In addition, your protected health information may be used and disclosed to a family member, friend, or other person to the extent necessary to assist you with your healthcare, but only with your authorization.

Person Involved in Care: In order to accommodate the notification of your location, your general condition, or death, your protected health information may be used or disclosed to a family member, your personal representative or another person responsible for your care. If you are present and wish to object to such disclosures of your protected health information you may do so. To the extent you are incapacitated or emergency circumstances exist, we will disclose protected health information using our professional judgment disclosing only protected health information that is directly relevant to the person's involvement in your healthcare. We will use our professional judgment and our experience with common practices to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of protected health information.

Marketing Health-Related Services: The use of your protected health information for the purpose of marketing communications is prohibited without you're written authorization.

Required by Law: Your protected health information may be used or disclosed if required by law.

Abuse or Neglect: As required by law, if we have reason to believe that you are the victim of possible abuse, neglect or domestic violence or other possible crimes, your protected health information may be disclosed to the appropriate authorities. If we have reason to believe the use or disclosure of your protected health information will prevent a serious threat to your health or safety or the health or safety of others we may have to provide the necessary protected health information.

National Security: Under some circumstances the military may require disclosure of health care information for armed forces personnel. For the purpose of national securities activities, counter intelligence and lawful intelligence, authorized federal authorities may require disclosure of protected health information. Protected health care information disclosure may be made to correctional facilities or law enforcement authorities with the lawful authority requiring custody of such information.

Appointment Reminders: Your protected health care information may be used to assist you with appointment reminders in the form of voicemail messages, postcards, or letters.

PATIENT RIGHTS

Access: At all times you have the right to review your protected health information, with limited exceptions. At your request, we will provide your information in a format other than photocopies. If we are able to do so we will accommodate your request.

Your request to obtain access to your information must be in writing. You may obtain a Protected health information Access Form by using the contact information at the end of this notice. We may need to charge you a reasonable cost-based fee for expenses including copies and staff time. You may also request access for submitting a letter using the information at the bottom of this notice. If you request copies, we will charge you $0.83 for the first 30 pages and $0.63 per page for all other pages plus $19.00 search and handling fee for staff time to locate and copy your protected health information. Copies of x-rays are charged a minimum of $10.00 per film. Postage will be included if you wish to have your information mailed. If you request a format option, which is different, we will charge a cost based fee for that format. An explanation of fees can be made available.

Disclosure Accounting: Your rights include the choice to receive a review of every time we or our business associates disclosed your protected health information for reasons other than treatment, payment, healthcare information and certain other activities for the last six years but not before April 14, 2003. Additional reasonable cost based fees may be extended if your requests for such information are more than one time per year.

Restrictions: You may request we apply additional restrictions to any disclosure of your health care information. We are not required to respond to the application of these additional restrictions. If we agree to follow your request regarding additional restrictions we will follow the agreed restrictions unless an emergency situation dictates otherwise.

Alternative Communication: Your rights include the instruction to request how you are communicated to regarding your protected health information. Your request must be in writing and can spell out other ways or others locations regarding your protected health information communication. You must identify agreed upon explanations of payment arrangements under alternative communications.

Amendment: You can initiate a written request to amend your protected health information. Included in the amendment must be an explanation why information should be amended. Certain conditions may exist where we may reject you request.

Electronic Notice: If you receive a notice electronically, you are entitled to receive the notice in writing as well.

QUESTIONS AND COMPLAINTS

If at any time you are unsure or concerned that your protected health information has not been protected or if you believe an error was made in the decision we made about accessing your protected health information; or in the response to a request you made to amend the use or disclosure of your protected health information; or to have us communicate to you by an alternative means or at an alternative locations, you have the right to bring this issue forward. You may make a complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U. S. Department of Health and Human Service at your request.

Privacy of your protected health information remains extremely important; we are committed to ensure your privacy. If you file a concern with the U.S. Department of Health and Human Resources we will not retaliate in anyway. We are available to assist you with any questions, concerns or complaints.