Patient Registration

Today's Date _____

Last Name _____ First Name _____ MI _____ Date of Birth _____ Age ____

Sex M or F Soc. Sec. # _____ Please Circle One: Single Married Separated Widow

Mailing Address _____ City _____ State ____ Zip Code _____

Email _____ Home Phone (_____)_____ Cell Phone (_____)_____

Driver's License # _____ Employer _____

Work Phone (_____)_____ Occupation _____

Are you a full time student? Yes or No If patient is a minor: Mother's DOB _____ Father's DOB _____

Name of Parent _____ Parent Soc. Sec. # _____

Parent Employer _____ Parent Phone (_____)_____

Person Responsible for Account _____ Relationship _____

Emergency Contact _____ Relationship _____ Phone # (_____)_____

If you are filling this form out on behalf of another person, what is your relationship to that person?

Name _____ Relationship _____

Reason for today's visit? _____

How did you hear about us?

☐ In-home Mailer ☐ Social Media ☐ Insurance ☐ Practice Website ☐ Internet ☐ Family/Friend/Coworker

☐ Other_____ *Who can we thank for your visit?* _____

Dental Insurance Information (Primary Carrier)

Insured's Name _____

Insured's Employer _____

Insured's DOB _____

Insurance ID # _____ Group # _____

Insurance Co _____

Insurance Co Address _____

Insurance Phone # _____

Dental Insurance Information (Secondary Coverage)

Insured's Name _____

Insured's Employer _____

Insured's DOB _____

Insurance ID # _____ Group # _____

Insurance Co _____

Insurance Co Address _____

Insurance Phone # _____

Dental History

On a scale of 1-10, with 10 being the highest rating:

How important is your dental health to you? 1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health? 1 2 3 4 5 6 7 8 9 10

Where do you want your dental health to be? 1 2 3 4 5 6 7 8 9 10

What would you like to change about your smile?

☐ Color ☐ Bite ☐ Chipped Teeth ☐ Spaces ☐ Crowding ☐ Smile Makeover ☐ Missing Teeth ☐ Whiter Teeth

Please share the following dates:

Your last cleaning _____/_____ Your last oral cancer screening _____/_____ Your last complete X-rays _____/_____

What is the most important thing to you about your future smile and dental health? _____

_____

What is the most important thing to you about your dental visit today? _____

_____

Why did you leave your previous dentist? _____

_____

Name of your previous dentist _____

Dental History Cont. - Please mark (x) any of the following conditions that apply to you

Patient Name (print) _____

Appearance

☐ Discolored teeth
☐ Worn teeth
☐ Misshaped teeth
☐ Crooked teeth
☐ Spaces
☐ Overbite
☐ Flat teeth

Pain/Discomfort

☐ Sensitivity (hot, cold, sweet)
☐ Pressure
☐ Broken teeth/fillings
☐ Worn teeth
☐ Dry Mouth

Function

☐ Grinding/Clenching
☐ Headaches
☐ Jaw Joint (TMJ) pain
☐ Jaw Joint (TMJ) clicking/popping
☐ Bad Bite
☐ Speech Impediment
☐ Mouth Breathing
☐ Sore Muscles (neck, shoulders)
☐ Difficulty Opening or Closing
☐ Difficulty Chewing on either side

Periodontal (Gum) Health

☐ Bleeding, Swollen, Irritated gums
☐ Bad breath
☐ Loose tipped, shifting teeth
☐ Previous perio/gum disease

Habits

☐ Thumb sucking
☐ Nail-biting
☐ Cheek/Lip biting
☐ Chewing on ice/foreign objects

Sleep Pattern or Conditions

☐ Sleep Apnea
☐ Snoring
☐ Daytime Drowsiness
☐ Bed wetting (for children)

Social

Tobacco
How much _____How long _____
Alcohol Frequency_____
Drugs Frequency _____

Previous Comfort Options

☐ Nitrous Oxide
☐ Oral Sedation (Pill)
☐ IV Sedation

Please list family history of any conditions marked:

_____
_____
_____
_____
_____
_____
_____

Medical History - Please mark (x) to your response to indicate if you have or have had any of the following

Cancer

Type _____
☐ Chemotherapy
☐ Radiation Therapy

Cardiovascular

☐ Angina (chest pain)
☐ Artificial Heart Valve
☐ Heart Conditions
☐ Heart Surgery
☐ High/Low Blood Pressure
☐ Mitral Valve Prolapse
☐ Pacemaker
☐ Rheumatic Fever
☐ Scarlet Fever
☐ Stroke

Endocrinology

☐ Diabetes
☐ Hepatitis A/B/C
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Thyroid Disease

Gastrointestinal

☐ Ulcers (Stomach)
☐ Gastrointestinal Disease

Hematologic/Lymphatic

☐ Anemia
☐ Blood Disorders
☐ Bruise Easily
☐ Excessive Bleeding

Musculoskeletal

☐ Arthritis
☐ Artificial Joints
☐ Jaw Joint Pain
☐ Rheumatoid Arthritis

Neurological

☐ Anxiety
☐ Depression
☐ Dizziness
☐ Drug/Alcohol Addiction
☐ Fainting
☐ Seizures
☐ Psychiatric Illness

Respiratory

☐ Asthma
☐ Emphysema
☐ Respiratory Problems
☐ Sinus Problems
☐ Sleep Apnea
☐ Tuberculosis

Viral Infections

☐ AIDS
☐ HIV Positive
☐ HPV

Women

☐ Currently Pregnant
☐ Nursing

Medical Allergies

☐ Antibiotics
(Penicillin/Amoxicillin /Clindamycin)
☐ Opioids
(Percocet, Oxycodone, Tylenol 3)
☐ Latex
☐ Local Anesthetics
☐ NSAIDs

Other Allergies

☐ _____

Additional Comments:

_____
_____

Are you under the care of a physician? Y or N If yes, please explain _____
_____

Physician Name_____Address:_____Phone(_____)_____

Have you had a serious illness, operation, or hospitalization in the past 5 years? Y or N, If yes please explain _____
_____
_____

Are you taking or have you recently taken any prescription or over the counter medicine(s)? Y or N If yes, please list all and why, including vitamins, natural or herbal supplements and/or dietary supplements _____
_____
_____

Have you ever in the past, or are you now currently taking any medications for Osteopenia/Osteoporosis or Bone Disease?
If so, please list medications: _____

Have you ever had surgery? If so, what type: _____
_____

Consent:

The undersigned hereby authorizes Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read, understand and agree to the above terms and conditions.

_____ _____ _____ _____

Signature of Patient/Legal guardian *Print Name* *Date* *Dentist Signature*

For completion by dentist only | Additional Comments

_____
_____
_____

Financial Policy

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment. Payment is due at the time service is provided. Our office accepts cash, personal checks, credit cards and outside patient financing.

Please Note: Returned checks will be subject to additional fees. If you fail to pay the office on time and it refers your account(s) to a third party for collection, a collection fee of 35% will be assessed and will be due at the time of the referral to the third party. If your account(s) are referred to an attorney or legal action is taken to recover the account(s) a collection fee of 35% will be assessed and will be due at the time of the referral to an attorney or legal action is taken. Such fee will not be assessed in states where it is prohibited by law.

Do You Have Insurance?

•We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company.

• As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however, it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits will determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.

• We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.

• We ask that you pay the deductible and co-payment, which is the estimated amount, not covered by your insurance company, by cash, check, credit card or Patient Financing at the time we provide the service to you.

• We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

We thank you for the opportunity to serve your dental health care needs and welcome any question you may have concerning your care or our financial policy.

Consent:

I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office.I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge and/or attorney fee will be added to any overdue balance. By signing below, you are authorizing us to call you at any number you provide including calls to mobile/cellular or similar devices for any lawful purpose. You agree to any fees or charges that you may incur for an incoming call from us, and/or outgoing calls to us, to or from any such number, without reimbursement from us.

Patient Name (*print*)	Patient Signature (*parent, if child*)	Date

****PLEASE FLIP OVER…THERE IS A BACKSIDE

PRIVACY POLICY CONSENT CLIENT RIGHTS AND HIPAA AUTHORIZATIONS

CLIENT RIGHTS AND HIPPA AUTHORIZATIONS

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time (HIPAA).

1. Tell your provider if you do not understand this authorization and the provider will explain it to you.

2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to the provider at the following address: 2515 E. Andrew Rd, Sherman, IL 62684:

3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, payment, enrollment or your eligibility for benefits. However, you may be required to complete this authorization form before receiving treatment if you have authorized your provider to disclose information about you to a third party. If you refuse to sign this authorization, and you have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a patient in their practice.

4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA. If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.

5. You may inspect or copy the protected dental information to be used or disclosed under this authorization. You do not have the right of access to the following protected dental information: psychotherapy notes, information compiled for legal proceedings, laboratory results to which the Clinical Laboratory Improvement Act (CLIA) prohibits access or information held by certain research laboratories. In addition, our provider may deny access if the provider reasonably believes access could cause harm to you or another individual. If access is denied, you may request to have a licensed health care professional for a second opinion at your expense.

6. If this office initiated this authorization, you must receive a copy of the signed authorization.

7. Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes. HIPAA provides special protections to certain medical records known as Psychotherapy Notes. All Psychotherapy Notes recorded on any medium by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separately from the rest of the clients medical records to maintain a higher standard of protection. Psychotherapy Notes are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separate from the rest of the individuals medical records. Excluded from the Psychotherapy Notes definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. Except for limited circumstances set forth in HIPAA, in order for a medical provider to release Psychotherapy Notes to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other dental records.

8. You have a right to an accounting of the disclosures of your protected dental information by the provider or its business associates. The maximum disclosure accounting period is the six years immediately preceding the accounting request. The provider is not required to provide an accounting for disclosures: (a) for treatment, payment, or dental care operations; (b) to you or your personal representative; (c) for notification of or to persons involved in an individual's dental care or payment for dental care, for disaster relief, or for facility directories; (d) pursuant to an authorization; (e) of a individuals in limited data set; (f) for national security or intelligence purposes; (g) to correctional institutions or law enforcement officials for certain purposes regarding inmates or lawful custody; or (h) incident to otherwise permitted or required uses or disclosures. Accounting for disclosures to dental oversight agencies and law enforcement officials must be temporarily suspended on their written representation that an accounting would likely impede their activities.

I authorize the following persons to have access to information covered under the Privacy Practice regarding myself.

LEAVE BLANK IF THERE IS NONE AND SIGN BELOW

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient's Signature: _____ Date:_____

Consent to receive electronic communications

We know you are busy. Let us help by sending automated reminders and more. Our office is now able to send email and text messages to patients to confirm appointments, let you know of upcoming events, and provide additional communication notifications! This is a great tool to utilize when a phone call isn't possible. However, we understand that some patients prefer to be called.

Please indicate if you would like to receive email and text message appointment confirmation and reminders, newsletters, marketing material, account updates and opportunities to provide feedback.

We may also use your information for direct and indirect marketing, including audience targeting.

You can withdraw your consent to receive electronic communications at any time by calling our office. Please note that you are responsible for providing our office with any updates to your email address and/or cell phone number.

Date

Printed name

Signature

Parent/ Guardian

Email address

Cell phone number

- ◯ Yes, I would like to receive electronic communications.
- ◯ No, please do not send me electronic communications.