YOUR LOVELY SMILE, OUR REWARD.

NEW PATIENT REGISTRATION FORM

Today's Date: _____ | Email Address: _____

PATIENT INFORMATION

Name

_____

Last First MI

Sex:

Marital status: □ Married □ Single □ Child □ Other

Personal

Birthdate: _____ **Address:** _____

SSN: _____ Street Apartment #

Phone (Home): _____ _____

Preferred method of contact: _____ City State Zip Code

HEALTH INFORMATION

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

□ AIDS	□ Excessive Bleeding	□ Liver Disease	□ Stroke
□ Allergies_____	□ Fainting	□ Mental Disorders	□ Tuberculosis
□ Anemia	□ Glaucoma	□ Nervous Disorders	□ Tumors
□ Arthritis	□ Growths	□ Pacemaker	□ Ulcers
□ Artificial Joints	□ Hay Fever	□ Pregnancy (Current/Past) Due Date:_____	□ Venereal Disease
□ Asthma	□ Head Injuries	□ Radiation Treatment	□ Codeine Allergy
□ Blood Disease	□ Heart Disease	□ Respiratory Problems	□ Penicillin Allergy
□ Cancer	□ Heart Murmur	□ Rheumatic Fever	□ OTHER
□ Diabetes	□ Hepatitis	□ Rheumatism	_____
□ Dizziness	□ High Blood Pressure	□ Sinus Problems	_____
□ Epilepsy	□ Jaundice	□ Stomach Problems	_____
	□ Kidney Disease		

- Have you ever had any complications following dental treatment? □ Yes □ No

If yes, please explain: _____

- Have you been admitted to a hospital or needed emergency care during the past two years? □ Yes □ No

If yes, please explain: _____

- Are you now under the care of a physician? Yes □ No□

If yes, please explain: _____

- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? □ Yes □ No

If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health. I will inform the doctors at the next appointment without fail.

_____ Signature of patient, parent or guardian Date: _____

Referral Information

Referred by: □ Dental Office □ Yellow Pages □ Newspaper □ School □ Work □ Another Patient, friend □ Relative □ Other_____

Name of person or office referring you to our practice: _____

HIPAA ACKNOWLEDGEMENT
CONSENT TO DISCLOSE PRIVATE HEALTHCARE INFORMATION
FOR TREATMENT, PAYMENT AND/OR HEALTHCARE OPERATIONS

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice.

We use and disclose health information about you for treatment, payment, and healthcare operations. For example: we may use or disclose your health information to a physician or other healthcare provider providing treatment to you; we may use and disclose your health information to obtain payment for services we provide to you, we may use and disclose your health information in connection with our healthcare operations (quality assessment, evaluating practitioner/provider performance, conducting training programs, accreditation, certification licensing or credentialing activities. We may use and disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes; we may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others; we may use and disclose your health information when we are required to do so by law.

In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time.

We will not use your health information for marketing communications without your written authorization.

_____ I give my consent to have my information released as indicated above.

_____ I do not give my consent to have my information released as indicated above.

Printed Name: _____ Date: _____

Patient

Signature: _____ Date: _____

Patient/Parent or Guardian of minor child

SPOUSE OR RESPONSIBLE PARTY INFORMATION

The following is for □ the patient's spouse □ the person responsible for payment

Name: _____ SSN: _____ Birthdate: _____

Sex: □ M □ F Address: _____

Marital status: □ Married □ Single Street Apartment #

□ Child □ Other _____

City State Zip Code

Phone: _____

EMPLOYMENT INFORMATION

The following is for □ the patient's spouse □ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____

Street City State Zip Code

INSURANCE INFORMATION

(Please give your Insurance and Driver License/Identification card to the receptionist.)

Primary Insurance

Name of Insured: _____ Is Insured a patient? □ Yes □ No

Last First MI

Insured's Birth Date: _____ Member ID#: _____ Group Number: _____

Insured's Address: _____

Street City State Zip Code

Patient's relationship to insured: □ Self □ Spouse □ Child □ Other _____

Insurance Plan Name and Address: _____

_____

Secondary Insurance

Name of Insured: _____ Is Insured a patient? □ Yes □ No

Last First MI

Insured's Birth Date: _____ Member ID#: _____ Group Number: _____

Insured's Address: _____

Street City State Zip Code

Patient's relationship to insured: □ Self □ Spouse □ Child □ Other _____

Insurance Plan Name and Address: _____

_____

CONSENT FOR SERVICES

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. 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. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that the fees estimate listed for this 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 therefore the 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 value of said services shall be as billed. 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 were 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.

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

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

_____

Signature of guarantor of payments/responsible party Date: _____ Relationship to Patient: _____

BROKEN APPOINTMENTS ARE NOT ACCEPTABLE

Please be advised that our office requires CONFIRMATION within
24 hours of your APPOINTMENT.
Without confirmation we may ask you to RESCHEDULE your APPOINTMENT.

Your appointment with the doctor is a time set aside for you and/or your child. If you need to change an appointment, we require A **24 HOUR NOTICE** . Failure to provide us with a 24 hour notice will be considered a broken appointment. Failure not to show for a scheduled appointment will result in a **$25.00 broken appointment fee**. Because of the hardship it places on our practice, repeat broke appointments will result in termination of our doctor/patient relationship.

Sign X _____

Date X _____

Preferred Method of Contact

□Email: _____

□Cell Phone: _____

□Home Phone: _____

□Text Message: _____

Signature: _____ Date: _____

Patient/Parent or Guardian