PATIENT REGISTRATION

ID: _____ Chart ID: _____

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder Preferred Name: _____

☐ Responsible Party

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: ____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

◯ Responsible Party is also a Policy Holder for Patient ◯ Primary Insurance Policy Holder ◯ Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ State / Zip: _____ _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ◯ Male ◯ Female Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2 Section 3

Employment Status: ◯ Full Time ◯ Part Time ◯ Retired

Student Status: ◯ Full Time ◯ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

Additional Comments:

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: .00 Rem. Deduct: _____.00

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

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PATIENT HIPPA ACKNOWLEDGEMENT AND DESIGNATION DISCLOSURE FORM

1. **Acknowledgement of the Practice's *Notice of Privacy Practices:*** By signing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices, and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices and agree to it's terms.

_____ _____ _____
Name of Patient Date of Birth Signature of Patient/Parent/Guardian Date

2. **Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative:** I agree that the practice may disclose health information to a personal representative of my choosing, since such person is involved with my health care or payment relating to my health care. In that case, the Practice will disclose information that is directly relevant to the person's involvement with my healthcare or payment relating to my healthcare. (Please list people we have permission to talk to about your health information below).

PRINT NAME_____RELATIONSHIP_____

PRINT NAME_____RELATIONSHIP_____

PRINT NAME_____RELATIONSHIP_____

_____ _____
Name of Patient (Print) Signature Date

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Whom can we thank for your referral? _____

Please let us know what you would like to achieve at your visit today. We would like to know what your main concern is so that we can address it with you.

_____

_____

If you could change anything about your smile, what would it be?

_____

Do you have any sensitive areas in your mouth?	Yes	No
Have you ever had any jaw/joint (TMJ) discomfort?	Yes	No
Do you have constant headaches or muscle aches?	Yes	No
Have you ever been diagnosed with sleep apnea?	Yes	No
Have you ever been told you have periodontal (gum) disease?	Yes	No
Have you had scaling and root planing (deep cleaning) in the past?	Yes	No
Does the appearance of your silver fillings bother you?	Yes	No
Are you interested in any cosmetic dentistry?	Yes	No
Would you like your teeth to be whiter?	Yes	No
Have you had braces in the past?	Yes	No
Do you wear a night guard for clenching or grinding?	Yes	No
Are you happy with the size and shape of your teeth?	Yes	No

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General Consent

Thank you for choosing Colerain and Western Hills Family Dentistry for your dental care. We are excited to work with you to help achieve excellent oral health. While recognizing the benefits of a healthy smile and teeth that function well, you should be aware that dental treatment, like treatment of any other part of your body, may have some inherent risks. These risks are seldom great enough to offset the benefits of treatment, but it is our responsibility to make you aware.

Benefits of dental treatment can include: relief of pain, the ability to chew properly and the confidence and social interaction that a healthy smile can bring. Nonetheless, there are some possible risks associated with dental procedures, including:

- Drug or chemical reaction. Dental materials may trigger allergic or sensitivity reactions.
- Long-term numbness (paresthesia). Local anesthetic, or its administration, while almost always adequate to allow comfortable care, can result in transient, or in rare instances permanent numbness.
- Muscle or joint tenderness. Holding one's mouth open can result in muscle or jaw joint tenderness, or in a predisposed patient, precipitate TMJ disorder.
- Sensitivity in teeth and gums and bleeding
- Swallowing or inhaling small objects

While we always follow procedural guidelines, which most often lead to clinical success, there are occasional cases, as with any medical treatment, that do not turn out as planned. We do our very best to assure that it does. Patient care and comfort is our utmost priority. Please feel free to ask questions in regards to all the dental procedures that are recommended to you. Thank you for reading the Financial Policy and General Consent.

I have read and understand the above statements:

_____ _____

Patient Signature Date

_____ _____

Parent Signature (if patient is a minor) Date

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Appointment Agreement

We request a minimum of two days notice to cancel or reschedule an appointment. If we are not extended the courtesy of a minimum two business days notice there will be a $50.00 Broken Appointment charge billed for each appointment affected. We understand that emergencies and illness are unpredictable, and reserve the right to credit such charges on an individual basis. Initial:_____

Text and E-Mail Reminders

When receiving courtesy texts and e-mail reminders, you may confirm your appointment on line, but if you need to move or cancel appointment you must phone the office. Initial:_____

Saturday Appointments

As a courtesy to patients we offer Saturday appointments. In order to reserve a Saturday appointment, patients will be required to pay half of their estimated co-payment at the time of SCHEDULING. This is only in an effort to provide Saturday appointments for our patients who truly need them and to provide the best care possible. Thank you for your cooperation.
If less than two business days notice is not given for cancellation, or you are a no show, for a Saturday appointment, you will not be extended the courtesy of a Saturday appointment in the future. Initial:_____

Signed: _____

Date: _____

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Statement of Financial Policy

At Colerain and Western Hills Family Dentistry, we are committed to providing you with the highest quality of care. We are pleased to discuss our professional charges with you at any time. Your clear understanding of our financial policy is important to our professional relationship.

- Payment is due at the time of service by the responsible party or by the parent/guardian that accompanies the minor. Unaccompanied minors will be seen at the digression of the doctor.
- We accept Cash, Checks, MasterCard, Visa, Discover and Care Credit(for non-insured patients only)

INITIAL:_____

INSURANCE BENEFITS ARE A CONTRACT BETWEEN YOU, YOUR EMPLOYER, AND YOUR BENEFIT COMPANY

- As a courtesy to our patients, we contact your benefit company to check on your benefit coverage prior to your appointments.
- We will file primary and secondary benefit claims.
- Benefit information is your responsibility and the estimates given to you as co-pays are intended to be only ***estimates***.
- We collect the estimated co-pays at the time of treatment.
- If you do not have your current benefit information or if benefit information cannot be verified***, full payment will be expected at the time of service***.
- We allow your insurance company 30 days to satisfy your claim. If the insurance company does not pay their portion in the time allotted the balance will be your responsibility.
- You may request a pre-determination on your recommended treatment.

INITIAL:_____

OVERDUE ACCOUNTS

- We reserve the right to turn over any account over 90 days to our attorney or credit agency for collection at an additional expense to you.
- We reserve the right to charge a monthly service charge for all accounts over 30 days in the amount of 1.5% or 18% annually.

_____ _____

Signature **date**