

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

Additional Comments:

Student Status: Full Time Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

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 <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 |
| Breathing 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 | Venereal 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 _____



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PATIENT HIPPA ACKNOWLEDGEMENT AND DESIGNATION DISCLOSURE FORM

- 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

- 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 business 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 for hygiene appointments.

The fee will be \$50.00 per hour of appointment time for Dr. Khetarpal procedures.

If above cancellation policy is violated for doctor treatment or Periodontal cleaning, then full patient payment will be required prior to rescheduling.

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.

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