

DATE: \_\_\_\_\_

### 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

Emergency contact #: \_\_\_\_\_

Student Status:     Full Time     Part Time

Referred By:: \_\_\_\_\_

Medicaid ID: \_\_\_\_\_ Pref. Dentist: \_\_\_\_\_

Kaiser Medical Rec #: \_\_\_\_\_

Employer ID: \_\_\_\_\_ Pref. Pharmacy: \_\_\_\_\_

Name of Univ./School: \_\_\_\_\_

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 \_\_\_\_\_

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?  Nursing?  
 Taking oral contraceptives?

Are you allergic to any of the following?

- Aspirin     Penicillin     Codeine     Acrylic     Metal     Latex     Local Anesthetics
- Other If yes, please explain: \_\_\_\_\_

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

- |   |  |  |  |   |
|---|--|--|--|---|
| <input type="checkbox"/> AIDS/HIV Positive      | <input type="checkbox"/> Chest Pains               | <input type="checkbox"/> Frequent Headaches    | <input type="checkbox"/> Irregular Heartbeat   | <input type="checkbox"/> Scarlet Fever              |
| <input type="checkbox"/> Alzheimer's Disease    | <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Genital Herpes        | <input type="checkbox"/> Kidney Problems       | <input type="checkbox"/> Shingles                   |
| <input type="checkbox"/> Anaphylaxis            | <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Glaucoma              | <input type="checkbox"/> Leukemia              | <input type="checkbox"/> Sickle Cell Disease        |
| <input type="checkbox"/> Anemia                 | <input type="checkbox"/> Convulsions               | <input type="checkbox"/> Hay Fever             | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Sinus Trouble              |
| <input type="checkbox"/> Angina                 | <input type="checkbox"/> Cortisone Medicine        | <input type="checkbox"/> Heart Attack/Failure  | <input type="checkbox"/> Low Blood Pressure    | <input type="checkbox"/> Spina Bifida               |
| <input type="checkbox"/> Arthritis/Gout         | <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> Heart Murmur          | <input type="checkbox"/> Lung Disease          | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Drug Addiction            | <input type="checkbox"/> Heart Pace Maker      | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> Artificial Joint       | <input type="checkbox"/> Easily Winded             | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Pain in Jaw Joints    | <input type="checkbox"/> Swelling of Limbs          |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Emphysema                 | <input type="checkbox"/> Hemophilia            | <input type="checkbox"/> Parathyroid Disease   | <input type="checkbox"/> Thyroid Disease            |
| <input type="checkbox"/> Blood Disease          | <input type="checkbox"/> Epilepsy or Seizures      | <input type="checkbox"/> Hepatitis A           | <input type="checkbox"/> Psychiatric Care      | <input type="checkbox"/> Tonsillitis                |
| <input type="checkbox"/> Blood Transfusion      | <input type="checkbox"/> Excessive Bleeding        | <input type="checkbox"/> Hepatitis B or C      | <input type="checkbox"/> Radiation Treatments  | <input type="checkbox"/> Tuberculosis               |
| <input type="checkbox"/> Breathing Problem      | <input type="checkbox"/> Excessive Thirst          | <input type="checkbox"/> Herpes                | <input type="checkbox"/> Recent Weight Loss    | <input type="checkbox"/> Tumors or Growths          |
| <input type="checkbox"/> Bruise Easily          | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Renal Dialysis        | <input type="checkbox"/> Ulcers                     |
| <input type="checkbox"/> Cancer                 | <input type="checkbox"/> Frequent Cough            | <input type="checkbox"/> Hives or Rash         | <input type="checkbox"/> Rheumatic Fever       | <input type="checkbox"/> Venereal Disease           |
| <input type="checkbox"/> Chemotherapy           | <input type="checkbox"/> Frequent Diarrhea         | <input type="checkbox"/> Hypoglycemia          | <input type="checkbox"/> Rheumatism            | <input type="checkbox"/> Yellow Jaundice            |

Have you ever had any serious illness not listed above?  Yes  No If yes, please explain: \_\_\_\_\_

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 \_\_\_\_\_

## CONSENT FOR SERVICES AND FINANCIAL CONSENT

I voluntarily and knowingly request and consent to the services, treatments and/or procedures recommended by the dentist and to all diagnostic methods deemed appropriate by the dentist which may include, but not be limited to, x-rays, study models, imagery, and other aids. I authorize the dentist to perform all such services, treatments and/or procedures and to utilize all such diagnostic methods. Further, I acknowledge and understand that the dentist may engage the assistance of others in performing such services, treatments, and/or procedures and utilizing such diagnostic methods.

I understand that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of services, treatments, procedures and/or diagnostic methods that have been recommended. I also understand that the use of anesthesia carries with it significant risks that have been explained to me.

I understand and acknowledge that I am fully and completely responsible for the payment of all costs associated with the services, treatment, procedures and/or diagnostic methods performed and utilized by the dentist and others. I acknowledge that any insurance coverage or managed care benefit that I may have is based on a contract between my insurance company or managed care company and me, my spouse and/or my employer. The dentist is not a party to this contract and the services, treatments, procedures and/or diagnostic methods are provided to me. Therefore, I acknowledge that I am fully responsible for the payment of all sums owed to the dentist for the services, treatments, procedures and/or diagnostic methods provided to me. As a *courtesy* to me, the dental office will bill my insurance company or managed care company and I acknowledge that I will remain liable for any and all amounts not paid by the insurance company or managed care company for any reason (including but not limited to the insurance company or managed care company declining coverage after initially approving it) or if the insurance company or managed care company fails for any reason to reimburse the dentist within 30 days after being billed by the dentist. I acknowledge that it is my responsibility to provide the dentist with my current insurance or managed care information and any changes thereto.

All returned checks will be subject to at \$25 returned check fee. Any account balances that remain unpaid for 90 days from the date of services shall accrue interest at the rate of 18 percent (18%) per year and may be referred to a collection company or attorney, unless a financial agreement is in place. In the event the unpaid account balance is forwarded to a collection company or attorney, I understand that I will be liable for collection costs of \$25. Further, in the event any unpaid account balance is referred to an attorney for collection, I agree also to be responsible for all costs and reasonable attorney's fees incurred in connection therewith.

I consent to the dentist's use and disclosure of my health information to my insurance company or managed care company and any agent thereof. I hereby assign to the dentist all of the insurance and managed care benefits due to me for the services, treatments, procedures and/or diagnostic methods provided to me and I authorize my insurance company and/or managed care company to make payment directly to the dentist for the costs associated therewith.

I further consent to be contacted by the dentist, any agent of the dental offices, or any collection agency (or agent thereof) or attorney to whom unpaid account balance has been assigned or referred by mail at any address that I provide to the dental office and/or by facsimile, email or phone number (whether a cell phone or landline) at any facsimile number, email address or phone number (whether a cell phone or landline) that I provide to the dental office or any agent of the dental office.

**SIGNATURE OF PATIENT,PARENT/GUARDIAN:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

**X-RAYS AND PHOTOS**

X-rays and Photographs in conjunction with a clinical exam are necessary in order to devise a complete and accurate diagnosis and dental treatment plan. Examination x-rays are generally taken once a year for adults and every 6 months for children. However, the frequency at which x-rays are taken will be determined based upon each patient's individual dental needs. If you deny recommended x-rays, you may be asked to sign an x-ray declination form.

**OFFICE CANCELLATION POLICY**

We pride ourselves in providing extra time for the personal attention each patient deserves. Your appointment time in this office will be reserved exclusively for you. We respect your time and make every effort to keep you from waiting. We request you provide us with at least 48 hour notice if you need to reschedule your appointment. We reserve the right to charge patients \$50 who do not reschedule their appointment with adequate notice, or fail to keep their scheduled appointments. We may also require a credit card to reserve an appointment at time of booking. A credit card hold transaction may be made on your credit card to reserve the appointment time. Your credit card information is stored with full encryption.

**HIPAA**

The Health Insurance Portability and Accountability Act (HIPAA) took effect on April 14, 2003. Our Notice of Privacy Practices is posted in our reception area. You may also request a paper or electronic copy. We would appreciate you taking the time to sign the bottom of this form certifying you have received/seen this office's Notice of Privacy Practices.

**PROPOSITION 65**

The state of California, under proposition 65, now requires every dentist to provide patients a copy of the information relating to materials and techniques used in the dental environment. This document, entitled "DENTAL MATERIALS FACT SHEET" is posted in our reception area, You may also request a paper or electronic copy. We would appreciate you taking the time so sign the bottom of this form certifying you have received/seen the Dental Materials Fact Sheet.

**SIGNATURE FOR RECEIPT OF DENTAL MATERIALS FACT SHEET  
OF PATIENT, PARENT/GUARDIAN:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

**SIGNATURE FOR RECEIPT OF NOTICE OF PRIVACY PRACTICES  
(YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT)**

**OF PATIENT, PARENT/GUARDIAN:** \_\_\_\_\_

**DATE:** \_\_\_\_\_