

# DENTAL REGISTRATION AND HISTORY

(PLEASE PRINT)



Date \_\_\_\_\_ Email \_\_\_\_\_ Home Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_

## PATIENT INFORMATION

Name \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
Last Name First Name Initial  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Sex ☐ M ☐ F Age \_\_\_\_\_ Birthdate \_\_\_\_\_  
☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced  
Patient Employed by \_\_\_\_\_ Occupation \_\_\_\_\_  
Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_  
Spouse or Parents name \_\_\_\_\_ Employer \_\_\_\_\_ Work # \_\_\_\_\_  
If Patient is a student, name or school/college \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_  
In case of emergency who should be notified? \_\_\_\_\_ Phone \_\_\_\_\_

## RESPONSIBLE PARTY

Name of Person Responsible for this Account \_\_\_\_\_ Relation to Patient \_\_\_\_\_  
Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
Driver's License # \_\_\_\_\_ Birthdate \_\_\_\_\_ Bank \_\_\_\_\_  
Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
Currently a Patient in our Office? ☐ Yes ☐ No S.S. # \_\_\_\_\_

## INSURANCE INFORMATION

Name of Insured \_\_\_\_\_ Last Name First Name Initial  
Relation to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
Address (if different from patient's) \_\_\_\_\_ Phone \_\_\_\_\_  
Person Responsible Employed by \_\_\_\_\_ Occupation \_\_\_\_\_ Date Employed \_\_\_\_\_  
Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Address \_\_\_\_\_  
Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_  
How much is your Deductible? \_\_\_\_\_ How much have you used? \_\_\_\_\_ Max. Annual Benefit \_\_\_\_\_  
Names of other dependents covered under this plan \_\_\_\_\_

## ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with \_\_\_\_\_  
Name of Insurance Company(ies)

and assign directly to Dr. \_\_\_\_\_ all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges not covered by insurance.

Date \_\_\_\_\_

Signature of Insured/Guardian \_\_\_\_\_



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?   | <input type="radio"/> Yes <input type="radio"/> No |        |
| Have you ever been hospitalized or had a major operation?   | <input type="radio"/> Yes <input type="radio"/> No |        |
| Have you ever had a serious head or neck injury?  | <input type="radio"/> Yes <input type="radio"/> No | If yes |
| Are you taking any medications, pills, or drugs?  | <input type="radio"/> Yes <input type="radio"/> No | If yes |
| Do you take, or have you taken, Phen-Fen or Redux?  | <input type="radio"/> Yes <input type="radio"/> No | If yes |
| Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? | <input type="radio"/> Yes <input type="radio"/> No | If yes |
| Are you on a special diet?  | <input type="radio"/> Yes <input type="radio"/> No | If yes |
| Do you use tobacco?   | <input type="radio"/> Yes <input type="radio"/> No | If yes |

Women: Are you...

|   |                                  |  |
|---|----------------------------------|--|
| <input type="checkbox"/> Pregnant/Trying to get pregnant? | <input type="checkbox"/> Nursing | <input type="checkbox"/> Taking oral contraceptives? |
|---|----------------------------------|--|

Are you allergic to any of the following?

|                                  |                                     |                                      |  |
|----------------------------------|-------------------------------------|--------------------------------------|--|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Codeine     | <input type="checkbox"/> Acrylic           |
| <input type="checkbox"/> Metal   | <input type="checkbox"/> Latex      | <input type="checkbox"/> Sulfa drugs | <input type="checkbox"/> Local Anesthetics |

|                                   |  |        |
|-----------------------------------|--|--------|
| Other?                            | <input type="checkbox"/>                           | If yes |
| Do you use controlled substances? | <input type="radio"/> Yes <input type="radio"/> No | If yes |

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 Problems <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 | <input type="radio"/> Yes <input type="radio"/> No | If yes |
|--|--|--------|

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: \_\_\_\_\_

X

Date: \_\_\_\_\_



# HIPAA Privacy Rule

## Receipt of Notice of Privacy Practices

### Written Acknowledgement Form

Acknowledgement of receipt of Information Practices Notice (§164.520(a))

I, \_\_\_\_\_, (patient's name) understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand that this facility's Notice of Privacy Practices provides a complete description of the uses and disclosures of my health information. I understand that:

- I have the right to review this facility's Notice of Privacy Practices prior to signing this acknowledgement
- This facility reserves the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy of any revised notice to the address I've provided if requested.

Signature of Individual or Legal Representative Witness \_\_\_\_\_

Printed Name of Individual or Legal Representative \_\_\_\_\_

Date: \_\_\_\_\_

#### **FOR OFFICE USE ONLY**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but it could not be obtained because:

Individual refused to sign

Communication barrier prohibited obtaining the acknowledgement

An emergency situation prevented us from obtaining acknowledgement

Others (please specify)

\_\_\_\_\_  
\_\_\_\_\_



## OUR FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy in which we require you read and sign prior to any treatment.

- PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED.
- We accept cash, check, all Credit Cards and Care Credit.
- We will file your insurance for you. However, you are responsible for what the insurance do not cover.
- If your insurance company will not send payment directly to Sauratown Dental you will be responsible for your total visit at the time of service.
- It is the ultimate responsibility of the patient to understand his/her insurance coverage.
- Patient without insurance will be responsible for full payment at the time of the service are rendered.
- The adult accompanying a minor are responsible for full payment of patient's portion at time of visit.
- The office requires 24-hour notice when canceling or re-scheduling an appointment.
- If three appointments are missed or re-scheduled with late notice you may be discharged from the practice.

Thank you for understanding our Financial Policy. Please let us know if you have any question or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy.

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Signature of Patient / Responsible Party

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Date