PATIENT REGISTRATION

Patient Information:

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

Preferred Name:_____

Address: _____

City, State, Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

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

Birth date:_____ Social Security #:_____ Drivers Lic#:_____

E-mail: _____ ☐ I would like to receive email correspondences

Patient Information (section 2):

Employment Status: o Full Time o Part Time o Self Employed o Retired o Unemployed

Student Status: oFull Time o Part Time

Preferred Pharmacy:_____ Referred By:_____

Responsible Party: (if someone other than the patient)

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

Address:_____

City, State, Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Birth date:_____ Social Security #:_____ Drivers Lic#:_____

o Responsible Party is Policy Holder for Patient o Primary Policy Holder o Secondary Policy Holder

Primary Insurance Information:

Name of Policy Holder: Policy Holder Birth date:

Relationship to Insured: oSelf oSpouse oChild o Other

Medicaid #: _____

Contract #: _____ Group #:_____ Insured Social Security #:_____

Employer:_____ Insurance Company:_____

Address:_____ Address: _____

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

Secondary Insurance Information:

Name of Policy Holder:_____ Policy Holder Birth date:_____

Relationship to Insured: oSelf oSpouse oChild o Other

Contract #_____ Group #:_____ Insured Social Security #: _____

Employer:_____ Insurance Company:_____

Address:_____ Address: _____

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

TIME 1:13 PM

Dodge City Dental Care

DATE 2/12/2013

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 _____

Information for our Patients

Payment Policy: Our office is a fee for service office, meaning we will politely ask for your portion of payment in full at the time services are rendered. For your convenience, we accept most Dental Insurances, Cash, Check, Visa, MasterCard and CareCredit.

As a courtesy to our patients, our office will assist you in obtaining the maximum benefit from you dental insurance.

Every dental insurance policy has a maximum benefit, which we are able to track for services in our office. If you have received care by another dental office, we cannot be responsible for calculating your remaining benefits accurately. You may want to call your insurance company to receive an updated amount after services have been paid to all offices involved.

I understand and agree that I am responsible for the deductible and the estimated amount not paid by the insurance company at the time of treatment. However, if our estimates are inaccurate, there will be a need to send you a billing statement for the balance due. We ask that you remit payment upon receipt of this statement.

We will electronically file your insurance within 24 hours of your appointment so that benefits may be paid quickly.

I hereby authorize benefits to be paid directly to this office. If services are excludable from coverage, I have been made aware of their fee in the treatment plan presented. I have read, understand and agree to the above statement. I understand that I am financially responsible for all charges regardless of my Dental Benefits.

Feel free to contact any member of our staff if you have any question regarding the payment options described above. We Thank you for trusting us with your dental care needs and hope that you will let us know if we can improve our services to you in any way.

Signature of Patient or Responsible Party Date

DODGE CITY DENTAL CARE
ACKNOWLEDGEMENT OF RECEIPT OF
HIPAA NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of this Dental Practice's **HIPAA Notice of Privacy Practices**.

_____
Patient Name (Please Print)

_____ _____
Patient Signature Date

OR

_____
Signature of Personal Representative

Authority of Personal Representative to Sign for Patient (check one):

□ Parent □ Guardian □ Power of Attorney □ Other: _____

Please Note: It is your right to refuse to sign this Acknowledgement.

Dental Office Use Only

I tried to obtain written Acknowledgement by the individual noted above of receipt of our **Notice of Privacy Practices**, but it could not be obtained because:

__ An emergency prevented us from obtaining acknowledgement.

__ A communication barrier prevented us from obtaining acknowledgement.

__ The individual was unwilling to sign.

__ Other:

_____

_____ _____
Staff Member Signature Date