PATIENT REGISTRATION

Today's Date______________

Patient's Name		Birth Date	Age	Sex: M F
Mailing Address	City	State	Zip	
Home Phone Number	Please Circle One: Child, Single, Married, Divorced, Widow		Your Soc Sec. #	
Your Employer	Occupation		Work Phone	

Are you a full time student? ▯Yes ▯ No

If patient is minor we need: *Mother's Birth Date* *Father's Birth Date*

Person responsible for account

Name of spouse (Parent if minor) E-mail address Cell Phone

Spouse's (parent's) employer Work phone

EMERGENCY INFORMATION:

Name & telephone of A Relative Not living with you.

Who may we thank for referring you?

Reason for your visit today:

DENTAL INSURANCE INFORMATION (Primary Carrier)	**Please complete this if you have secondary dental insurance**
Insured's name	Insured's name
DOB SS#	DOB SS#
Insured's employer	Insured's employer
Insurance Co	Insurance Co
Insurance Co Address	Insurance Co Address
Phone #	Phone #
Group #	Group #

Is there any other medical or dental information we should know about?

Patient Signature (Parent if patient is a minor) **Date**

DENTAL HISTORY

Check any that apply

- -Sensitivity (hot, cold, sweet) ▯
  Where? UR LR UL LL
- -Headaches, earaches, neck pain ▯
- -Jaw joint pain ▯
- -Teeth or fillings breaking ▯
- -Grinding or clenching teeth ▯
- -Bleeding, swollen or irritated gums ▯
- -Loose, tipped or shifting teeth ▯
- -Bad breath ▯

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

- -Dentures ▯
- -Partial dentures ▯
- -Braces ▯
- -Gum treatments ▯

Please share the following dates:

-Your last cleaning ___/___
-Your last oral cancer screening ___/___
-Your last complete X-Rays ___/___

Name of Previous Dentist ____________________
City ____________________ **State** ________
Phone Number ____________________
What is the most important thing to you about your Smile and dental health? ____________________

Do you smoke or use chewing tobacco? ▯
How much? For how long?

If I could change my smile, I would:

- -Make them whiter ▯
- -Make them straighter ▯
- -Close spaces ▯
- -Replace black metal fillings with tooth colored restorations ▯
- -Repair chipped teeth ▯
- -Replace missing teeth ▯
- -Replace old crowns that don't match ▯
- -Have a smile makeover ▯

-How important is your dental health to you?
Very Somewhat Not Important

-Where would you rate your current dental health?
Good Fair Not Good

Over the counter medications you are currently taking (Please include Herbal)

MEDICAL HISTORY

Please check any of the following that apply to you:

▯ Allergies (Seasonal)
▯ Anemia
▯ Arthritis
▯ Artificial Heart Valve
▯ Artificial Joints
▯ Asthma
▯ Blood Disease
▯ Bruise Easily
▯ Cancer
▯ Chemotherapy
▯ Diabetes
▯ Dizziness
▯ Drug Addiction
▯ Emphysema
▯ Excessive Bleeding
▯ Fainting
▯ Glaucoma
▯ Heart Conditions
▯ Heart Lesions (Congenital)
▯ Heart Murmur
▯ Heart Surgery
▯ Hepatitis A
▯ Hepatitis B
▯ Hepatitis C
▯ High Blood Pressure
▯ Jaundice
▯ Jaw Joint Pain
▯ Kidney Disease
▯ Liver Disease
▯ Low Blood Pressure
▯ Mitral Valve Prolapse
▯ Nervousness/Depression
▯ Pacemaker
▯ Phen Fen (1 month +)
▯ Radiation (head/neck)
▯ Respiratory Problems
▯ Rheumatic Fever
▯ Rheumatism
▯ Scarlet Fever
▯ Seizures
▯ Stomach Problems
▯ Stroke
▯ Thyroid Disease
▯ Tuberculosis
▯ Ulcers
▯ Venereal Diseases
▯ Other

For WOMEN Only

▫ Birth Control Pills
▫ Nursing
▫ Pregnant
1-3 mos, 3-6 mos, 6-9 mos,

Do you have any of the following drug allergies?

▯ Aspirin
▯ Darvon
▯ Erythromycin
▯ Local Anesthetic
▯ Nitrous Oxide
▯ Penicillin
▯ Percodan
▯ Valium
▯ Other

Are you under a physician's care? What for?

____
____

Family Physician ____________________ **Phone Number** ____________________

HIPPA Privacy Form

<u>Acknowledgement of Receipt of Notice of Privacy Practices</u>

Purpose: This signed agreement acknowledges receipt of our Notice of Privacy Practices and documents our good faith effort to obtain that acknowledgement*

*You may refuse to sign this acknowledgement

I have received a copy or explanation of this office's Notice of Privacy Practices.

____________________________________ ____________________

Signature of Patient/Guardian Date

Relationship to Patient> Self or Other______________________________

For Office Use Only

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

- Individual refused to sign
- Communication challenges (such as a language barrier) which prohibited obtaining acknowledgement
- An emergency situation prevented us from obtaining acknowledgement at time of service
- Other (Please specify)

____

____

Representative for Dr. Kent Hales (Logo here? Or dba Advanced Dentistry)

____ Date__________________

A word about insurance

From Advanced Dentistry

The Office of Dr. Kent Hales

We are finding that insurance companies are becoming less cooperative as time goes on. They are frequently rejecting treatment that the doctors deem necessary for our patients in support of their good oral health. The fees we quote you are fair and very competitive for our market. We will assist you in the submission of your insurance and do all we can to cooperate with the requirements put forth by your carrier. Please do note that there are never any fee guarantees when working with these companies and often they will not approve recommended treatment (or greatly reduce their portion of the payment). We ask that you are diligent and take an active role communicating with your carrier. The agreement (policy) is between you and the insurance company and not your dentist. We appreciate your confidence in Advanced Dentistry and are proud to have you as a part of our dental family.