ADVANCED DENTAL CARE
ADULT REGISTRATION FORM

Today's date: (Please Print)

PATIENT INFORMATION

Patient's last name: First: M.I.:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

What do you prefer to be called?	Birth date: / /	Social Security No.:	Age:	Sex: ❑ M ❑ F

Mailing address:			Home phone no.: ( )
City:	State:	Zip:	Employer phone no.: ( )
Employer:	Occupation:		Cell phone no.: ( )

Referred to office by:	❑ Family/Friend (Name)			❑ Dr.
	❑ Insurance Plan	❑Internet or Website	❑ Close to home or work	❑ Yellow Pages

Are there any other family members seen in our office (please list):

EMAIL ADDRESS:

ACCOUNT INFORMATION

Person responsible for bill:	Address (if different):		Home phone no.: ( )
LA Driver's License Number:	Birth date: / /	Social Security No.:	Employer phone no.: ( )
Employer:	Occupation:		Cell phone no.: ( )

Is this person covered by insurance? ❑ Yes ❑ No	Please indicate **Primary** insurance:

Subscriber's Name:	Birth date: / /	Subscriber's SSN:	Group No.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone:	Work phone:

1. I hereby authorize doctor/staff to take x-rays, study models, photos, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of this patient's dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. **I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made.** In the event payments are not received by agreed upon dates, I understand that a 1.75% late charge may be added to my account. If required, I also understand a check of my credit history may be made and all collection fees will be passed onto me.
4. **I UNDERSTAND IT IS MY RESPONSIBILITY TO INFORM THE OFFICE OF ANY CHANGES TO MY MEDICAL STATUS.**

Patient/Guardian Signature:	Date:

ADULT HEALTH HISTORY QUESTIONNAIRE

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE STRICLY CONFIDENTIAL AND WILL BECOME PART OF YOUR MEDICAL RECORD.

Patient Name (Last, First, M.I.):		
Previous dentist:	Date of last x-rays:	Date of last dental exam:

PERSONAL MEDICAL HISTORY

Medical Doctor:	Telephone no.:
Specialty Doctor:	Telephone no.:

Please check any conditions you have been diagnosed with or currently have:				
	☐	Heart (Surgery, Disease, Attack)	☐	Tuberculosis
	☐	Chest Pain	☐	Asthma
	☐	Congenital Heart Disease	☐	Glaucoma
	☐	Heart Murmur	☐	Latex Sensitivity
	☐	High Blood Pressure	☐	Allergies / Hives
	☐	Mitral Valve Pressure	☐	Sinus Trouble
	☐	Artificial Heart Valve	☐	Radiation / Chemotherapy
	☐	Heart Pacemaker	☐	Tumors / Cancer
	☐	Rheumatic Fever	☐	Hepatitis (Circle) Type A Type B Type C
	☐	Arthritis / Rheumatism		When:
	☐	Cortisone Medicine	☐	AIDS / HIV Positive
	☐	Swollen Ankles	☐	Venereal Disease
	☐	Stroke When:	☐	Cold Sores / Fever Blisters
	☐	Artificial Joint	☐	Hemophilia / Sickle Cell Disease
		Where: When:	☐	Liver Disease / Yellow Jaundice
	☐	Blood Thinner	☐	Blood Transfusion
	☐	Diabetes	☐	Epilepsy / Seizure
	☐	Thyroid Problems	☐	Fainting / Dizzy Spells
	☐	Kidney Problems	☐	Nervous / Anxious
	☐	Ulcers	☐	Psychiatric / Psychological Care
	☐	Emphysema	☐	Neurological Disorders
	☐	Chronic Cough	☐	Do you use tobacco?
	☐	Osteoporosis		Form and frequency:
		Do you take medication for this?	☐	Have you ever used recreational drugs?

Do you have or have you had any disease, condition or problem not listed? ☐ Yes ☐No If yes, please list:

Have you been under the care of a medical doctor during the past 2 years? ☐ Yes ☐No If yes, for what:

Have you taken any prescription medications or drugs in the past two years? ☐ Yes ☐No If yes, please list:

Are you taking any drug, prescription medication, over-the-counter medication, vitamin or herbal supplement now? ☐ Yes ☐No If yes, please list:

Are you aware of having an allergic or adverse reaction to any medication or local anesthesia? ☐ Yes ☐No If yes, please list:

Hospitalizations in the last 5 years

Year	Reason

Women Only

Are you pregnant? ☐ Yes, _____months ☐ No Nursing? ☐ Yes ☐ No Taking Birth Control Pills? ☐ Yes ☐ No

DENTAL HISTORY

What would you like to improve about your smile?		
I would like whiter teeth.	❑ Yes	❑ No
I would like to eliminate spaces.	❑ Yes	❑ No
I would like to repair the teeth that are chipped or broken.	❑ Yes	❑ No
I would like to replace the teeth that are missing.	❑ Yes	❑ No
Are you dissatisfied with any of your current dental work?	❑ Yes	❑ No
❑ Upper right back teeth ❑ Upper left back teeth ❑ Upper front teeth		
❑ Lower right back teeth ❑ Lower left back teeth ❑ Lower front teeth		
Are you aware of clenching or grinding your teeth?	❑ Yes	❑ No
Would you like for our hygiene department to teach you how to care for your teeth?	❑ Yes	❑ No
Have you ever had an upsetting dental experience?	❑ Yes	❑ No
Have you ever had any periodontal (gum) treatment?	❑ Yes	❑ No
Do you think you will wear a denture someday?	❑ Yes	❑ No

HIPAA CONSENT

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Information Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent, I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct and indirect treatment by other healthcare providers not involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

______________________________ ____

Today's Date Print Patient Name

____

Signature of Patient or Parent/Guardian

BROKEN APPOINTMENT POLICY

I understand that a fee will be charged for appointments missed without a 24 hour notice given. This fee will start at $50, depending on the length of my appointment time.

Patient Name:____ Today's Date: ____________________

Credit Card Number: __________________________________ VISA MC AMEX DISC Expiration Date: ___________

Signature of Patient or Parent/Guardian: ____