Dental Registration

patient information

Thank you for choosing our practice for your dental needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

(Please Print)

Name ______________________________ Date________ SS/HIC/Patient ID#________________
First Middle Initial Last

Address ______________________ City _______________ State ______ Zip_____________

Sex: ❑ Female ❑ Male Birthdate _____________ E-mail _____________________________

Home Phone (_____)___________ Cell Phone (_____)___________ Work Phone (_____) __________

Patient Employer/School __________________________ Occupation ______________________

Employer/School Address _______________________ City ___________ State ______ Zip__________

Spouse or parent's name _______________ Employer ___________ Work Phone (_____) __________

Whom may we thank for referring you to us? ______________________________________

Person to contact in case of emergency ________________________ Phone (_____) __________

responsible party

Name of person responsible for this account ____

Relationship to patient ______________________ Phone (_____)____________________

Address ______________________________ City ___________ State ______ Zip__________

Name of employer ___________________________ Work Phone (_____) ______________

insurance information

Name of insured _____________________ Relationship to patient __________________________

Birthdate _____________ Social Security # _________________ Date employed ______________

Name of employer _______________________ Work Phone (_____)_______________________

Address ______________________________ City ___________ State ______ Zip __________

Insurance Co. _____________________ Group #____________ Employer #_________________

Insurance Co. Address ____________________ City ___________ State ______ Zip __________

How much is your deductible? ________ How much have you used? ________ Max. annual benefit? __________

DO YOU HAVE ADDITIONAL INSURANCE? ❑ No ❑ Yes IF YES, PLEASE COMPLETE THE FOLLOWING:

Name of insured _____________________ Relationship to patient__________________________

Birthdate _____________ Social Security # _________________ Date employed ______________

Name of employer _______________________ Work Phone (_____)_______________________

Address ______________________________ City ___________ State ______ Zip __________

Insurance Co. _____________________ Group #____________ Employer #_________________

Insurance Co. Address ____________________ City ___________ State ______ Zip __________

dental history

Name ______________________ Age _____ Date of last exam ______________

Former Dentist ______________________ Date of last dental X-rays ______________

Reason for today's visit ______________________

How often do you brush? ______________ How often do you floss? ______________

Please check any of the following conditions that apply to you:

- ❑ Bad breath
- ❑ Bleeding gums
- ❑ Clicking or popping jaw
- ❑ Food collection between teeth
- ❑ Grinding teeth
- ❑ Loose teeth or broken fillings
- ❑ Periodontal treatment
- ❑ Sensitivity to cold
- ❑ Sensitivity to heat
- ❑ Sensitivity to sweets
- ❑ Sensitivity when biting
- ❑ Sores or growths in your mouth

medical history

Physician ______________________ Date of last visit ______________

Please list all medications you are currently taking: ______________________

Allergies: ______________________

(Women) Are you pregnant? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No Taking birth control pills? ❑ Yes ❑ No

Check (✓) if you have had any of the following:

- ❑ AIDS
- ❑ Anemia
- ❑ Arthritis, Rheumatism
- ❑ Artificial Heart Valves
- ❑ Artificial Joints
- ❑ Asthma
- ❑ Back Problems
- ❑ Bleeding Abnormally
- ❑ Blood Disease
- ❑ Cancer
- ❑ Chemical Dependency
- ❑ Chemotherapy
- ❑ Circulatory Problems
- ❑ Congenital Heart Lesions
- ❑ Cortisone Treatments
- ❑ Cough, Persistent
- ❑ Cough up blood
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Fainting
- ❑ Glaucoma
- ❑ Headaches
- ❑ Heart Murmur
- ❑ Heart Problems
  Describe __________
- ❑ Hemophilia
- ❑ Hepatitis
- ❑ Hernia Repair
- ❑ High Blood Pressure
- ❑ Immune System Disorders
- ❑ Jaw Pain
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Mitral Valve Prolapse
- ❑ Nervous Problems
- ❑ Pacemaker
- ❑ Psychiatric Care
- ❑ Radiation Treatment
- ❑ Respiratory Disease
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Shortness of Breath
- ❑ Skin Rash
- ❑ Stroke
- ❑ Swelling of Feet or Ankles
- ❑ Thyroid Problems
- ❑ Tobacco Habit
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Ulcer
- ❑ Venereal Disease

Have you ever taken any of these medications?

Diet Medications: ❑ Dexfenfluramine ❑ Fen-phen ❑ Pondimin ❑ Redux

Blood Thinners: ❑ Coumadin ❑ Warfarin ❑ Fosamax or Actonal for osteoporosis

Other: ❑ Levoxyl ❑ Synthroid ❑ Zometa or Avedia for cancer

certification and assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with ______________________
Name of Insurance Company(ies)

and assign directly to Dr. ______________________ all insurance 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 authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

______________________ ______________
Signature of Patient, Parent, Guardian or Personal Representative — Date

______________________ ______________
Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

Cancellation Policy

Lisa N. Powell, DMD, MS, PA
3750 NW Cary Parkway, Suite 114
Cary, NC 27513
919-468-1026

Patient____**Date**________________

Our policies on missed appointements are as follows:

Please give us at least **24 hours** notice if you cannot keep your scheduled appointment. There will be a charge of $50.00 per scheduled hour for a cancellation, if the appointment is broken or cancelled with less than 24 hours notice.

When longer appointments are made, appointments longer than 60 minutes, we ask you give us **48 hours** notice if the appointment cannot be kept.

With today's busy schedules and life's demands, changes are sometimes unavoidable. This courtesy is always appreciated.

I confirm that I have read and fully understand the above.

Patient's Signature______________________________________**Date**______________

New Patient Consent Form

Lisa N. Powell, DMD, MS, PA
3750 NW Cary Parkway, Suite 114
Cary, NC 27513
919-468-1026

Patient____**Date**____________

I hereby authorize Dr. Lisa Powell and her associates at 3750 NW Cary Parkway, Suite 114, Cary, North Carolina 27513 to perform upon me, the named patient, the following procedures:

A dental examination, including the x-rays needed for diagnostic purposes. At the completion of this visit, the results of the exam will be reviewed with me and treatment options explained.

I acknowledge that no guarantees or assurances have been made to me concerning the results intended from the procedures.

I confirm that I have read and fully understand the above.

I hereby consent to the proposed dental treatment.

Patient's Signature__________________________________**Date**________________

Lisa N. Powell, DMD, MS, PA
3750 NW Cary Parkway, Suite 114
Cary, North Carolina 27513
919-468-1026

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, ____________________________, have received a copy of this offices notice of
(Please print name)
Privacy Practices.

____
(Signature)

____
(Date)

For Office Use Only

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

[ ] Individual refused to sign

[ ] Communication barriers prohibited obtaining the acknowledgement

[ ] An emergency situation prevented us from obtaining acknowledgment

[ ] Other (please specify)____