PATIENT REGISTRATION

How did you hear about us? _____

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

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name: _____

Responsible Party (if someone other than the patient)

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

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ State / Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

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

Birth Date: _____ Age: _____ Soc Sec: _____ Drivers Lic: _____

E-mail: _____ ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Section 3

Medicaid ID: _____

Employer ID: _____

Carrier ID: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____

Address: _____

Address 2: _____

City, State, Zip: _____

Ins. Company: _____

Address: _____

Address 2: _____

City, State, Zip: _____

Rem. Benefits: _____ Rem. Deduct: _____

Patient Preferences

What is your preferred pharmacy? _____

Address: _____ Address 2: _____

City: _____ State / Zip: _____ Phone Number: _____

Do you prefer AM or PM appointments? ☐ AM ☐ PM ☐ No Preference

Would you like to be on short notice for available appointments? ☐ Yes ☐ No

If you are on short notice, we may contact you within 24 hours of an available appointment. If you choose to accept the appointment, the broken appointment policy will still apply for failed appointments.

Hope Still, D.D.S.

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

Women: Are you...

Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin, Penicillin, Codeine, Acrylic, Metal, Latex, Sulfa Drugs, Local Anesthetics

Do you use controlled substances?	Yes No	If yes
Other?		If yes

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 Problems	Yes No	Frequent Headaches	Yes No	Liver Disease	Yes No	Bruise Easily	Yes No
Stroke	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	Convulsions	Yes No	Heart Trouble/Disease	Yes No
Psychiatric Care	Yes No	Yellow Jaundice	Yes No	Ulcers	Yes No		

Have you ever had any serious illness not listed Yes 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: _____

New Patient Form

Name: **Date:**

Please check any of the following problems that apply to you.

- ☐ Headaches, earaches, neck pain
- ☐ Jaw joint pain
- ☐ Teeth or fillings breaking
- ☐ Grinding teeth
- ☐ Sensitivity (hot, cold, sweet) Where?
  - ☐ Upper Right
  - ☐ Lower Right
  - ☐ Upper Left
  - ☐ Lower Left
- ☐ Clenching teeth
- ☐ Bleeding, swollen, or irritated gums
- ☐ Loose, tipped, or shifting teeth
- ☐ Bad breath

Do you smoke or use chewing tobacco?

☐ Yes ☐ No How much? _____ For how long? _____

Do you/have you had any of the following:

- ☐ Dentures
- ☐ Partial Dentures
- ☐ Braces
- ☐ Periodontal (gum) treatments

Have you ever been tested for sleep apnea? ☐ Yes ☐ No

Have you been diagnosed with sleep apnea? ☐ Yes ☐ No

Do you currently wear a CPAP device? ☐ Yes ☐ No

Previous Dental Experience:

Please share the following dates:

- ☐ Your last cleaning: _____
- ☐ Your last oral cancer screening: _____
- ☐ Your last complete x-rays: _____

Name of Previous Dentist:_____

Address_____

City_____State_____Zip_____

Phone Number_____

What is the most important thing to you about your future smile and dental health?

What is the most important thing to you about your dental visit today?

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

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 dental status.

Signature of Patient, Parent, or Guardian_____Date_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

I,_____, have received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

Authorization to Release Information

Purpose: This form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself.

****You may refuse to sign this acknowledgement; however, refusal denies us the ability to file your insurance.****

I,_____, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

_____	_____
{Please Print Name}	Relationship
_____	_____
{Please Print Name}	Relationship
_____	_____
{Please Print Name}	Relationship

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
- ☐ Communications barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify):

_____

_____

_____

FAMILY **SMILES** DENTAL

BROKEN APPOINTMENT POLICY

A broken appointment is an appointment scheduled by the patient that is cancelled or rescheduled without giving our office 48 hour notice, or an appointment that you failed to show up for. We require 48 hour notice for all appointment changes. The following actions will be taken upon missed appointments.

1st missed appointment - We will gladly reschedule your appointment and remind you of our office policy.

2nd missed appointment - You will receive a written notification of the missed appointments and may be charged a fee of $50.00.

3rd missed appointment - You will be charged an additional broken appointment fee up to $75.00.

4th missed appointment - You may be required to pay an appointment reservation fee of $200.00 or possibly be dismissed from our practice.

X_____ Date:_____

Signature of Patient, Parent, or Guardian