# PATIENT REGISTRATION

First Name: _____ Last Name: _____
Patient Is: (circle one) Policy Holder Responsible Party

Responsible Party (if someone other than the patient)
First Name: _____ Last Name:_____
Address: _____ Address2: _____
City, State, Zip:_____ Pager:_____
Home Phone: _____ Work:_____EXT:____ Cellular: _____
Birth Date: _____ Soc. Sec: _____ Drivers Lic:_____
Responsible Party Is: (circle one) Same as Patient Insurance Policy Holder

Patient Information:
Address:_____ Address2: _____
City: _____ State/Zip: _____
Home Phone:_____Work: _____EXT:_____ Cellular:_____
Sex (circle one) Female Male Martial Status: Married Divorced Single Widowed
Birth Date: _____ Age: ____ Soc. Sec:_____ Drivers Lic:_____
E-Mail_____ Referred By:_____

Section 2:
Employment Status:(circle one) Full Time Part Time Retired
Student Status: Full Time Part Time
Pref. Pharmacy & Phone: _____
Emergency Contact: _____ Contact #:_____
Relationship to Patient: _____

Primary Insurance Information:
Name of Insured: _____ Relationship to Patient: Self Spouse Child Other
Insured Soc. Sec:_____ Insured Birth Date: _____
Employer:_____ Insurance Company: _____
Insurance Company Address & Phone:_____
_____

Secondary Insurance Information:
Name of Insured: _____ Relationship to Patient: Self Spouse Child Other
Insured Soc. Sec: _____ Insured Birth Date:_____
Employer:_____ Insurance Company: _____
Insurance Company Address & Phone: _____

# MEDICAL HISTORY

Although dental personnel primarily treat the area in and around the 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 under a physician's care now? (circle one) Yes No if yes, please explain_____
Have you ever been hospitalized or had a major operation? Yes No explain: _____
Have you ever had a serious head or neck injury? Yes No if yes, explain:_____
Are taking any medications, pills, or drugs? Yes No If yes, please explain:_____
Do you use tobacco? Yes No if yes; How long? _____ How many a day? _____
Do you controlled substances? Yes No if yes, please explain _____

Women: Are You; pregnant or trying to get pregnant? ____ Taking contraceptives? _____Nursing? _____

Are you allergic to any of the following?: (circle those that apply)
Aspirin Penicillin Codeine Acrylic Metal Latex Local Atheistics
Other:_____

Do you have, or have you had, any of the following?
Mitral Valve Prolapse Heart Pace Maker Artificial Joint Irregular Heartbeat

Have you ever undergone? :
Chemotherapy or Radiation Treatments

Do you have, or have you had, any of the following? (circle those that apply)

| | | |
|---|---|---|
| o AIDS/HIV Positive | o Epilepsy or Seizures | o Sickle cell Disease |
| o Alzheimer's Disease | o Excessive Bleeding | o Sinus Trouble |
| o Anaphylaxis | o Excessive Thirst | o Spina Bifida |
| o Anemia | o Fainting Spells/Dizziness | o Stomach/Intestinal Disease |
| o Angina | o Frequent Cough | o Stroke |
| o Arthritis/Gout | o Frequent Diarrhea | o Swelling of Limbs |
| o Artificial Heart Valve | o Frequent Headaches | o Thyroid Disease |
| o Asthma | o Glaucoma | o Tonsillitis |
| o Blood Disease | o Kidney Problems | o Tuberculosis |
| o Blood Transfusion | o Leukemia | o Tumors or Growths |
| o Breathing Problems | o Liver Disease | o Ulcers |
| o Bruise Easily | o Low Blood Pressure | o Venereal Disease |
| o Chest Pains | o Lung Disease | o Yellow Jaundice |
| o Cold Sores/Fever Blisters | o Pain in Jaw Joints | o Hay Fever |
| o Congential Heart Disorder | o Parathyroid Disease | o Heart Murmur |
| o Convulsions | o Psychiatric Care | o Heart Attack/Failure |
| o Cortisone Medicine | o Renal Dialysis | o Hemophilia |
| o Diabetes | o Rheumatic Fever | o Herpes |
| o Drug Addiction | o Scarlet Fever | o High Blood Pressure |
| o Easily Winded | o Shingles | o Hypoglycemia |
| o Emphysema | o Hives or Rash | o Rheumatism |

Have you ever had any serious illness not listed above? Yes No If Yes, please explain:_____
_____
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.

Patient Signature:_____

## PLEASE READ CAREFULLY

I, the patient, understand that I am responsible for any charges incurred for services provided by **Gentle Dental Care**.

If I have dental insurance, I understand that my claim will be submitted as a courtesy by **Gentle Dental Care**. I understand that I have the contract with my insurance company, and it is **my** responsibility to make sure that my account is paid in full, either by them or me. I give permission for payment from my insurance company to be sent to **Gentle Dental Care** and understand if no payment is made by the insurance company after 60 days from my visit, payment is expected from me. I understand that if I have not paid the balance on my account in **full** 90 days after my insurance company has paid, I will be billed an interest charge of 1.5% per month. I authorize **Gentle Dental Care t**o release any medical information necessary to process my claim. If I have a co-pay/deductible, I understand that it is due on the day of my visit.

If I do not have dental insurance, I understand that payment for services is due at the time services are provided. For my convenience, **Gentle Dental Care** accepts Cash, Check, MasterCard, Visa, Discover, and American Express. Deferred Interest Payment Plans of 6-12 months are available through Care Credit, for those who qualify. Deferred Interest Payment Plans of 18 months will incur a $75.00 processing fee.

I, the patient, authorize **Gentle Dental Care** to take X-rays, study models, photographs or any other diagnostic aids deemed appropriate, to make a thorough diagnosis of the patient's dental needs. I also authorize **Gentle Dental Care** to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand that the use of anesthetic agents embodies a certain risk.

Effective immediately, patients must notify our office 48 hours in advance of their appointment to cancel or reschedule appointments. If appointments are not canceled within 48 hours, I understand that my account will be charged a $50.00 "**No Show"** fee.

_____ _____

Signature of Patient Date

_____ _____

Signature of Responsible Party Date

# HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Our Notice of Privacy Practices provides information about how Forest Dental Partners may use and disclose your protected health information and when we need your written authorization to do so. This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Name of Patient (print): _____
Date of Birth: _____

**I. My Authorization**

I authorize _____ to use or disclose the following health information:

- ❑ All of my health information
- ❑ My health information relating to the following treatment or condition:

  _____
- ❑ My health information covering the period of healthcare from _____ (Start Date) to _____ (End Date).
- ❑ Other:_____

**The above party may disclose this health information to the following recipient:**

Name/Organization:

_____

Phone: _____ Fax: _____

Email: _____

**The purpose of this authorization is (check all that apply):**

- ❑ At my request
- ❑ To authorize the using or disclosing party to communicate with me for marketing purposes when they receive payment from a third party to do so.
- ❑ To authorize the using or disclosing party to sell my health information. I understand that the seller will receive compensation for my health

information and will stop any future sales if I revoke this authorization.

- ❏ Other:
  _____
  _____
  _____

**This authorization ends:**

- ❑ On (Date): _____
- ❑ When I am no longer a patient of the practice.
- ❑ When the following event occurs:
  _____

**II. My Rights**

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party. I understand that uses and disclosures already made based upon my original permission cannot be taken back. I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards. I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization. I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature of Patient: _____
Date: _____

If the patient is a minor or unable to sign please complete the following:

- ❏ Patient is a minor: _____ years of age
- ❏ Patient is unable to sign because:
  _____

Authorized Representative Signature: _____

Date: _____

Print Name of Representative:

_____

Authority of representative to sign on behalf of patient:

❑ Parent ❑ Legal Guardian ❑ Court Order ❑ Other:

_____

**III. Additional Consent for Certain Conditions**

This medical record may contain information about physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment. Separate consent must be given before this information can be released.

❑ I consent ❑ I do not consent

Signature of Patient or Authorized Representative:

_____

Date: _____ Time: _____

**IV. Additional Consent for HIV/AIDS**

This medical record may contain information concerning HIV testing and/or AIDS diagnosis or treatment. Separate consent must be given to have this information released.

❑ I consent ❑ I do not consent

Signature of Patient or Authorized Representative:

_____

Date: _____ Time: _____

**V. Notice of Privacy Practices**

The signature below indicates that I have been provided with a copy of the Notice of Privacy Practices for the authorized party listed above and have read and understood its content.

Signature of Patient or Authorized Representative:

_____

Date: _____ Time: _____