DALEVILLE DENTIST
GENTLE CARE FOR THE FAMILY

Patient Registration

Patient Name: _____ Date of Birth: _____

Responsible Party: _____ Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Marital Status: _____ Single _____ Married _____ Divorced _____Separated _____ Widowed

Home Phone: _____ Cell Phone: _____

Work Phone: _____ E-mail: _____

Social Security #: _____ Preferred Pharmacy: _____

How did you hear about our office? _____

Insurance Information (Policy Holder)

Primary Policy Holder's Employer: _____

Dental Insurance Provider: _____

Policy Holder's Name: _____ Date of Birth: _____

Policy Holder's Address: _____

Policy Holder's Phone #: _____ Policy Holder's Social Security #: _____

Group Number: _____ Member ID Number: _____

Secondary insurance (if applicable)

Primary Policy Holder's Employer: _____

Dental Insurance Provider: _____

Policy Holder's Name: _____ Date of Birth: _____

Policy Holder's Address: _____

Policy Holder's Phone #: _____ Policy Holder's Social Security #: _____

Group Number: _____ Member ID Number: _____

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		
Do you use controlled substances?	Yes No	If yes	

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

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	Stroke	Yes No
Bruise Easily	Yes No	Genital Herpes	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	Ulcers	Yes No
Convulsions	Yes No	Heart Trouble/Disease	Yes No	Psychiatric Care	Yes No	Venereal Disease	Yes No
Yellow Jaundice	Yes No						

Have you ever had any serious illness not listed above? 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:_____

DALEVILLE DENTIST
GENTLE CARE FOR THE FAMILY

Patient HIPAA Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance 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 or indirect treatment by other health care providers involved in treatment)
- Obtaining payment from third party payers (e.g. insurance companies)
- The day-to-day healthcare operations of the practice

I have also been informed of and given the right to review and secure a copy of the 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 Daleville Dentist reserves the right to change the terms of this notice from time to time and that I may contact the practice 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. I also understand that I am 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.

Print Patient Name: _____

Patient/Guardian Signature: _____ Date: _____

I approve releasing my information to the following people:

_____

_____

_____

DALEVILLE DENTIST
GENTLE CARE FOR THE FAMILY

Assignment and Release

I hereby authorize payment directly to Daleville Dentist for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges and services rendered to me or my dependents, whether paid or not paid by insurance. I authorize the above doctor(s) and/or provider or supplier of services in this office to release any of my medical or financial information required to secure payment of benefits and to carry out any necessary treatment, payment activities, and health care operations. I authorize the use of this signature on all insurance submissions.

Financial Policy

Your account will be considered past due if not paid within 90 days of our initial bill. In addition to the principle amount owed, should your account become past due, you agree to pay us liquidated damages calculated as twenty-five percent (25%) of the current principle balance on your account in addition to attorney's fees, court cost, and interested at 1.5% from the date of service. I also understand that I am billed a $35.00 return check fee for any checks returned for insufficient funds.

Office Policy

A minimum charge may be billed for missed or cancelled appointments without prior notification of 24 hours. I understand that failure to give a 24 hour notice that I cannot keep a reserved appointment may result in a missed appointment fee of $50.00 and, should this happen 3 times, will result in dismissal from the practice. Our office reserves the right to refuse appointments for late cancellations as well as failure to attend. Please remember that once an appointment is made, this time is reserved especially for you.

Consent for Use/Disclosure of Health Information

By signing this form you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and health care operations. Your signature also indicates that you have had full opportunity to read and consider our Notice of Privacy Practices, and that you understand that you have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact person listed on that notice. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you and or to continue treating you if you revoke this consent.

I, the undersigned, understand and agree to the policies stated above. I certify that the information on this form is accurate, to the best of my knowledge.

_____ _____

Patient Name (Printed) Date

_____

Signature (Guardian if under 18 years old)