Patient Registration Form

American Dental Association
www.ada.org

Email: Today's Date:

Preferred Name: ❑ Miss ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. Referred by:

Name: Last First Middle Home Phone: *include area code* ( ) Cell Phone: *include area code* ( )

Address: Mailing address City: State: Zip:

SS#: Date of Birth: Sex: M F

Employer: Business Phone: *include area code* ( )

Emergency Contact: Relationship: Home Phone: *include area code* ( ) Cell Phone: *include area code* ( )

College Student Status: ❑ Full Time ❑ Part Time Please provide school info: School Name:

Employment Status: ❑ Full Time ❑ Part Time ❑ Retired Address:

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed Address 2:

Pref. Pharmacy: Phone: ( ) City, State, Zip:

Dental Insurance Information

Primary Insurance Information

Name of Insured: Relationship to Patient: ❑ Self ❑ Spouse ❑ Child ❑ Other

Insured Soc. Sec.: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

ID#: Gr#:

Secondary Insurance Information

Name of Insured: Relationship to Patient: ❑ Self ❑ Spouse ❑ Child ❑ Other

Insured Soc. Sec.: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

ID#: Gr#:

Dental Information For the following questions, mark (X) your responses to the following questions.

	Yes	No	DK
Do your gums bleed when you brush or floss?	❑	❑	❑
Are your teeth sensitive to cold, hot, sweets or pressure?	❑	❑	❑
Is your mouth dry?	❑	❑	❑
Have you had any periodontal (gum) treatments?	❑	❑	❑
Have you ever had orthodontic (braces) treatments?	❑	❑	❑
Have you had any problems associated with previous dental treatment?	❑	❑	❑
Is your home water supply fluoridated?	❑	❑	❑
Do you drink bottled or filtered water?	❑	❑	❑
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY			
Are you currently experiencing dental pain or discomfort?	❑	❑	❑

	Yes	No	DK
Do you have earaches or neck pains?	❑	❑	❑
Do you have any clicking, popping or discomfort in the jaw?	❑	❑	❑
Do you brux or grind your teeth?	❑	❑	❑
Do you have sores or ulcers in your mouth?	❑	❑	❑
Do you wear dentures or partials?	❑	❑	❑
Do you participate in active recreational activities?	❑	❑	❑
Have you ever had a serious injury to your head or mouth?	❑	❑	❑

Date of your last dental exam:
What was done at that time?

Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

over

Medical Information Please mark (X) your responses to indicate if you have or have not had any of the following diseases or problems.

(Check DK if you Don't Know the answer to the question) Yes No DK

Are you now under the care of a physician? ☐ ☐ ☐
Physician Name: _____
Phone: *Include area code* (____) _____
Address/City/State/Zip: _____

Are you in good health? ☐ ☐ ☐
Has there been any change in your general health within the past year? ☐ ☐ ☐
If yes, what condition was treated? _____

Date of last physical exam: _____

Do you wear contact lenses? ☐ ☐ ☐

Are you taking, or have you taken, any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine) or fen-phen (fenfluramine-phentermine combination)? ☐ ☐ ☐

Are you taking or scheduled to begin taking either of the medications alendronate (Fosamax®) or risendronate (Actonel®) for osteoporosis or Paget's disease? ☐ ☐ ☐

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastic cancer? ☐ ☐ ☐
Date Treatment Began: _____

Yes No DK

Have you had a serious illness, operation or been hospitalized in the past 5 years? ☐ ☐ ☐
If yes, what was the illness or problem? _____

Are you taking or have you recently taken any prescription or over the counter medicine(s)? ☐ ☐ ☐
If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements: _____

Do you use controlled substances (drugs)? ☐ ☐ ☐

Do you use tobacco (smoking, snuff, chew, bidis)? ☐ ☐ ☐
If so, how interested are you in stopping?
Circle one: VERY / SOMEWHAT / NOT INTERESTED

Do you drink alcoholic beverages? ☐ ☐ ☐
If yes, how much alcohol did you drink in the last 24 hours? _____
If yes, how much do you typically drink in a week? _____

WOMEN ONLY Are you:
Pregnant? ☐ ☐ ☐
Number of weeks: _____
Taking birth control pills or hormone replacement? ☐ ☐ ☐
Nursing? ☐ ☐ ☐

Joint Replacement. Have you had an orthopedic total joint replacement (hip, knee, elbow, finger)? ☐ ☐ ☐
Date: _____ If yes, have you had any complications?

Allergies - Are you allergic to, or have you had a reaction to: Yes No DK
To all yes responses, specify type of reaction.

Local anesthetics	☐	☐	☐	Metals	☐	☐	☐
Aspirin	☐	☐	☐	Latex (rubber)	☐	☐	☐
Penicillin or other antibiotics	☐	☐	☐	Iodine	☐	☐	☐
Barbituates, sedatives, or sleeping pills	☐	☐	☐	Hay fever / seasonal	☐	☐	☐
Sulfa drugs	☐	☐	☐	Animals	☐	☐	☐
Codeine or other narcotics	☐	☐	☐	Food	☐	☐	☐
				Other	☐	☐	☐

	Yes	No	DK
Heart murmur	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Artificial heart valves	☐	☐	☐
Rheumatic fever	☐	☐	☐
Cardiovascular disease	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Coronary artery disease	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Congenital heart defects	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐

	Yes	No	DK
Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, date: _____			
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/ Radiation treatment	☐	☐	☐

	Yes	No	DK
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/Persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐
Glaucoma	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐

	Yes	No	DK
Neurological disorders	☐	☐	☐
If yes, specify: _____			
Sleep disorder	☐	☐	☐
Mental health disorders	☐	☐	☐
If yes, specify: _____			
Recurrent infections	☐	☐	☐
Type of infection: _____			
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/ Migraines	☐	☐	☐
Severe of rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ☐ ☐ ☐
Name of physician or dentist making recommendation: _____ Phone: (____) _____
Do you have any disease, condition, or problem not listed above that you think I should know about? ☐ ☐ ☐
Please explain: _____

NOTE: Both Doctor and patient are encouraged to discuss any and all relevent patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will reyl on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.
Signature of Patient/Legal Guardian: _____ Date: _____

Noe Valley
Smiles and Braces

Patient Name: _____

Confirmation & Cancellation Policy

Noe Valley Smiles & Braces understands that your time is very valuable and we hope you agree that our time is equally valuable. It is with that understanding that we have implemented a 48 business hour cancellation policy. If an appointment is cancelled with less than 48 business hours notice you will be subject to a cancellation fee based on the amount of time that you have reserved. You are responsible for confirming all appointments via phone or email 24 hours in advance to secure your appointment time.

Consent for Electronic Communications

We provide our patients the option to participate in our electronic communications system. Some of these features include the ability to:

- *Request appointments online*
- *Confirm appointments via e-mail*
- *Receive text message appointment reminders*
- *Submit patient satisfaction surveys*
- *Refer friends and family online*

You may opt out of our electronic communications systems at any time by clicking "unsubscribe" link found in the footer of each e-mail or by replying to a text message with 'STOP.' Standard text messaging rates apply.

☐ Check here to opt out of text message communication.

☐ Check here to opt out of e-mail communication.

** We use this information to provide you with excellent treatment. We may disclose Patient Health Information (PHI) to third parties that perform services for this dental practice in the administration of your benefits in accordance with HIPAA. These parties are required by law to sign a contract agreeing to protect the confidentiality of your PHI. Your PHI may be disclosed to an affiliate that performs services for this dental practice in the administration of your benefits. Our affiliates do not sell, share, or rent our users' personally identifiable information unless required by law, do not send any e-mail or other communications without user permission, and do not send spam.*

SIGNATURE OF RESPONSIBLE PARTY: _____

Relationship: _____ Date: _____

Noe Valley Smiles and Braces

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES ("Acknowledgement")

Last Updated April 1, 2011

I acknowledge that I have received a copy of this Dental Practice's **HIPAA Notice of Privacy Practices.**

_____
Patient Name (Please Print)

_____ _____
Patient Signature Date

OR

_____
Signature of Personal Representative

Authority of Personal Representative to Sign for Patient (check one):

□ Parent □ Guardian □ Power of Attorney □ Other: _____

Please Note: It is your right to refuse to sign this Acknowledgement.

Dental Office Use Only

I tried to obtain written Acknowledgement by the individual noted above of receipt of our **Notice of Privacy Practices,** but it could not be obtained because:

__ An emergency prevented us from obtaining acknowledgement.

__ A communication barrier prevented us from obtaining acknowledgement.

__ The individual was unwilling to sign.

__ Other:_____

_____ _____
Staff Member Signature Date

Noe Valley
Smiles and Braces

Financial Agreement

It is our goal for patients to clearly understand their treatment needs, as well as their financial responsibility, before treatment begins. Payment of estimated patient portion is due at the time of treatment. We desire to make dental treatment affordable to all of our patients. Therefore, we offer the following payment options:

1) Flexible payment plans of up to 6 months upon approval with Care Credit®. Approval must be received prior to treatment date.
2) Cash, Check or Visa/MasterCard/Discover/American Express

As a courtesy to you we will gladly process your insurance claim forms. Our responsibility is to provide you with the treatment that best meets your needs, not to try to match your care to insurance plan limitations. Dental insurance plans do not correspond to individual patient needs, and as such, many routine and necessary dental services are not covered even though you may need those services.

We understand insurance guidelines can be hard to understand and overwhelming at times. Fortunately with the information provided to us by you and your insurance company we are able to provide some assistance in estimating your insurance benefit. However, your insurance company makes final determination once treatment is completed and the claim is submitted. Your insurance is contract between you and your insurance company; therefore, all charges are your responsibility.

Once an insurance claim reaches 60 days the estimated insurance balance will become your responsibility. You will have to contact your insurance provider for reimbursement.

All insurance benefits are payable to the dental office, and I agree to release any information necessary for the dental office to process claims.

I realize I am financially responsible for all charges incurred, regardless of insurance coverage. I am responsible for all collection costs incurred by the dental office and on a returned check, a fee of $35.00.

Name of Patient:_____ Date of Birth:_____

Signature of Patient or Legal Guardian: _____ **Date:**_____