PATIENT REGISTRATION

Patient's Name: _____ **Date:** _____
first middle last

Preferred Name: _____ **DOB:** _____-_____-_____ **SSN:** _____-_____-_____

Home Address: _____
street city state zip

Home Phone: _____-_____-_____ **Work Phone:** _____-_____-_____ **Cell Phone:** _____-_____-_____

Single: _____ Married: _____ Separated: _____ Widowed: _____ Divorced: _____

Patient's Occupation: _____ **Employer:** _____

Patient's Email: _____

Responsible Party: _____
first middle last

DOB: _____-_____-_____ **SSN:** _____-_____-_____

Occupation: _____ **Employer:** _____

Home Phone: _____-_____-_____ **Work Phone:** _____-_____-_____ **Cell Phone:** _____-_____-_____

In case of an Emergency: _____

Relationship to patient: _____

Home Phone: _____-_____-_____ **Work Phone:** _____-_____-_____ **Cell Phone:** _____-_____-_____

Whom may we thank for recommending you to our office? _____

INSURANCE

PRIMARY COVERAGE	**SECONDAY COVERAGE**
Policy Holder: _____	Policy Holder: _____
DOB:_____ SSN:_____	DOB:_____ SSN:_____
Employer:_____	Employer:_____
Insurance Company: _____	Insurance Company: _____
ID/Policy Number: _____	ID/Policy Number: _____
Group Number:_____	Group Number:_____
Phone Number: _____	Phone Number: _____
Claims Address: _____	Claims Address: _____
_____	_____
Coverage: FAMILY **( )** INDIVIDUAL **( )**	Coverage: FAMILY **( )** INDIVIDUAL **( )**

The information I have provided is complete and accurate to the best of my knowledge. I consent to whatever procedures are deemed to necessary to diagnose my oral condition. I agree to be responsible for my payment of all services rendered.

Patient's Signature: _____ **Today's Date:** _____

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

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

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 Problem ◯ 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

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 _____ DATE _____

Dental History:

1. When was your last dental visit? _____
2. How often do you brush? _____
3. Do you floss? **( ) YES ( ) NO**
4. Have you ever had orthodontic treatment? **( ) YES ( ) NO**
5. Do you clench your jaws or grind your teeth? **( ) YES ( ) NO**
6. Have you ever worn a nightguard? **( ) YES ( ) NO**
7. Do you use tobacco products? **( ) YES ( ) NO** How often? _____
8. Do you consume alcohol? **( ) YES ( ) NO** How often? _____
9. Do you drink sodas? **( ) YES ( ) NO** How often? _____
10. Do your gums ever bleed? **( ) YES ( ) NO** When? _____
11. Are your teeth sensitive? **( ) YES ( ) NO** If yes, what to?
    (Example: hot, cold, sweets) _____
12. Do you have areas where you trap food? **( ) YES ( ) NO**

Please circle the answer that best describes your dental health

1)

a) My mouth is very comfortable
b) My mouth is moderately comfortable
c) My mouth is uncomfortable

2)

a) I feel that the appearance of my mouth is very good
b) I am satisfied with the appearance of my mouth
c) My mouth is uncomfortable

3)

a) I have always completed the care that was recommended for my dental health
b) I have not done what dentists have recommended for my mouth
c) I rarely go to the dentist and only do what is necessary to be free of pain

Patient Consent

Clinical

1. I authorize David Dickerson, DDS of 21st Century Aesthetic Dentistry to perform all recommended treatment.
2. I authorize the practice to take radiographs, study models, photos, and other diagnostic aids or materials as needed to make a thorough diagnosis. I authorize that such diagnostic material may be released to a third-party payers and/or other health care professionals.
3. I authorize the use of anesthetics, sedatives, and other medication, as needed. I am fully aware that using anesthetic agents involve certain risks, including but not limited to redness and swelling of tissues, pain, itching, vomiting, dizziness, miscarriage, cardiac arrest, drowsiness, and/or lack of coordination.

Financial

1. I am responsible for payment for all services rendered on my behalf. I understand that payment is due when serves are rendered. Should my account become delinquent, I will be responsible for all additional collection costs, including reasonable attorney fees.
2. **FULL PAYMENT IS DUE AT TIME OF SERVICE. WE ACCEPT CASH, CHECKS, MASTERCARD, VISA, DISCOVER, AND AMERICAN EXPRESS. WE OFFER ACCESS TO EXTENDED PAYMENT PLANS WITH CREDIT APPROVAL.**
3. We may accept assignment of insurance benefits, however the balance is your responsibility whether your insurance company pays or not. We cannot file your insurance unless you give us your complete insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid on your claim within 45 days, the full balance will automatically be transferred to you.
4. **I AM AWARE THAT TO HOLD OPERATING COSTS, 24 HOURS NOTICE OF CANCELLATION IS REQUIRED.**

Insurance

5. I authorize the practice to release to staff, hospitals, health care service plans, insurance companies, self-insurers or their representatives, any and all information, records, and other diagnostic material about my medical history, services rendered, or recommended treatment.

I have read this Patient Consent form and agree to all terms and conditions herein.

Patient's Name:_____ Date: _____

Patient's Address: _____

If patient is a child, please provide the parental or legal guardian's consent:

Signature:_____ Relationship:_____ Date:_____

David Dickerson, DDS

21st Century Aesthetic Dentistry

Your Privacy Is Important to Us

Acknowledgement of Receipt of Notice of Privacy Policies

I have received a copy of the Notice of Privacy Practices of David Dickerson, DDS of 21st Century Aesthetic Dentistry. I hereby authorize, as indicated by my signature below, 21st Century Aesthetic Dentistry to use and to disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form.

_____ _____

Print Name Address

_____ _____

Signature Date

Please check your preferred means of communication:

☐ You may contact me at my home telephone number _____-_____-_____

☐ You may contact me on my cell phone _____-_____-_____

☐ You may contact me on my work telephone number _____-_____-_____

☐ You may send me an email at: _____

☐ Other: _____

Please list authorized persons with whom we may discuss your Protected Health Information (PHI). Please notify use if you desire to remove a name from this list in the future.

1. _____ **Relationship:** _____**Date:** _____
2. _____ **Relationship:** _____**Date:** _____
3. _____ **Relationship:** _____**Date:** _____

*****For office use only*****

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

☐ Individual refused to sign

☐ Communication barriers prohibited by obtaining the acknowledgment

☐ An emergency situation prevented us from obtaining the acknowledgment

☐ Other (please specify) _____

Staff Person Initials: _____