

PATIENT REGISTRATION

ID: _____ Chart ID: _____

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

Patient Is: Policy Holder Preferred Name: _____
 Responsible Party

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 Full Time Part Time Retired Section 3

Employment Status: _____ Referred By: _____

Student Status: Full Time Part Time Additional Comments: _____

Medicaid ID: _____ Pref. Dentist: _____ Emergency Contact: _____

Employer ID: _____ Pref. Pharmacy: _____ Emergency Contact #: _____

Carrier ID: _____ Pref. Hyg.: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: 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: _____

Rem. Benefits: _____ .00 Rem. Deduct: _____ .00

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: 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: _____

Rem. Benefits: _____ .00 Rem. Deduct: _____ .00

MEDICAL HISTORY

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?
Have you ever been hospitalized or had a major operation?
Have you ever had a serious head or neck injury?
Are you taking any medications, pills, or drugs?
Do you take, or have you taken, Phen-Fen or Redux?
Are you on a special diet?
Do you use tobacco?
Do you use controlled substances?

Women: Are you Pregnant/Trying to get pregnant? Taking oral contraceptives? Nursing?

- Are you allergic to any of the following?
Aspirin, Penicillin, Codeine, Acrylic, Metal, Latex, Local Anesthetics, Other

Do you have, or have you had, any of the following?

- AIDS/HIV Positive, Alzheimer's Disease, Anaphylaxis, Anemia, Angina, Arthritis/Gout, Artificial Heart Valve, Artificial Joint, Asthma, Blood Disease, Blood Transfusion, Breathing Problem, Bruise Easily, Cancer, Chemotherapy, Chest Pains, Cold Sores/Fever Blisters, Congenital Heart Disorder, Convulsions, Cortisone Medicine, Diabetes, Drug Addiction, Easily Winded, Emphysema, Epilepsy or Seizures, Excessive Bleeding, Excessive Thirst, Fainting Spells/Dizziness, Frequent Cough, Frequent Diarrhea, Frequent Headaches, Genital Herpes, Glaucoma, Hay Fever, Heart Attack/Failure, Heart Murmur, Heart Pace Maker, Heart Trouble/Disease, Hemophilia, Hepatitis A, Hepatitis B or C, Herpes, High Blood Pressure, Hives or Rash, Hypoglycemia, Irregular Heartbeat, Kidney Problems, Leukemia, Liver Disease, Low Blood Pressure, Lung Disease, Mitral Valve Prolapse, Pain in Jaw Joints, Parathyroid Disease, Psychiatric Care, Radiation Treatments, Recent Weight Loss, Renal Dialysis, Rheumatic Fever, Rheumatism, Scarlet Fever, Shingles, Sickle Cell Disease, Sinus Trouble, Spina Bifida, Stomach/Intestinal Disease, Stroke, Swelling of Limbs, Thyroid Disease, Tonsillitis, Tuberculosis, Tumors or Growths, Ulcers, Venereal Disease, Yellow Jaundice

Have you ever had any serious illness not listed above? If yes, please explain:

Comments:

Blank lines for patient 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

GENERAL DENTISTRY INFORMED CONSENT**1. WORK TO BE DONE**

I understand that I am having the following work done: Exam, X-rays, Prophylaxis (Cleaning), and Other. (Initials _____)
(Initials _____)

2. DRUGS AND MEDICATION

I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock.
(Initials _____)

3. CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. For example, root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary.
(Initials _____)

4. REMOVAL OF TEETH

Alternatives to removal of teeth have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.), and I authorize the Dentist to remove the following teeth _____ and any other necessary for reasons in paragraph # 3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (paresthesia) that can last for an indefinite period of time or fractured jaw. I understand I may need further treatment by a specialist if complications arise during or following treatment, the cost of which is my responsibility.
(Initials _____)

5. CROWNS, BRIDGES AND CAPS

I understand that no guarantee has been given that the proposed treatment will be to my complete satisfaction. I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size and color) will be before cementation. It is also my responsibility to return for permanent cementation within 20 days from tooth preparation. Excessive delays may allow for tooth movement. This may necessitate a remake of the crown, bridge or cap. I understand there will be additional charges for remakes due to my delaying permanent cementation.
(Initials _____)

6. ENDODONTIC TREATMENT (ROOT CANAL)

I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally root canal filling material may extend through the tooth, which does not necessarily affect the success of the treatment. I understand the endodontic files and reamers are very fine instruments and stresses vented in their manufacture can cause them to separate during use. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy). I understand that the tooth may be lost in spite of all efforts to save it.
(Initials _____)

7. PERIODONTAL LOSS (TISSUE AND BONE):

I understand that I have a serious condition, causing gum and bone inflammation or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I understand that undertaking any dental procedures may have a future adverse affect on my periodontal condition.
(Initials _____)

8. FILLINGS

I understand that care must be exercised in chewing on fillings, especially during the first 24 hours to avoid breakage. I understand that a more extensive filling that originally diagnosed may be required due to additional decay. I understand that significant sensitivity is a common after effect of a newly placed filling.
(Initials _____)

9. DENTURES

I understand the wearing of dentures is difficult. Sore spots, altered speech, and difficult in eating are common problems. Immediate denture (placements of denture immediately after extractions) may be painful. Immediate denture may require considerable adjusting and several relines. A permanent reline will be needed later. This is not included in the denture fee. I understand that it is my responsibility to return for delivery of the dentures. I understand that failure to keep my delivery appointment may result in poorly fitted denture(s). Is a remake is required due to my delays of more than 30 days, there will be additional charges.
(Initials _____)

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment, which I have requested and authorized. I understand that no other Dentist is responsible for my dental treatment.

I hereby authorize any of the doctors of dental auxiliaries to proceed with an perform the dental restorations and treatments as explained to me. I understand that this is only an estimate and subject to modification depending on unforeseen or undiagnosed circumstances that may arise during the course of treatment. I understand that regardless of any dental insurance coverage I may have, I am responsible for payment of dental fees. I agree to pay any attorney's fees, collection fees, or court costs that may be incurred to satisfy this obligation.

Signature of Patient or Guardian X _____ Date _____

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name	Date of Birth	Medical Record Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol, or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
- 6. THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:	
8. Name and address of person(s) or category of person to whom this information will be sent:	
9(a). Specific information to be released:	
<input type="checkbox"/> Medical Record form (insert date) _____ to (insert date) _____ <input type="checkbox"/> Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers. <input type="checkbox"/> Other: _____	
Include: <i>(Indicate by Initialing)</i> _____ Alcohol/Drug Treatment _____ Mental Health Information _____ HIV-Related Information _____ Genetic Testing	
Authorization to Discuss Health Information (b). <input type="checkbox"/> By initialing here _____ I authorize _____ <div style="display: flex; justify-content: space-between; width: 80%; margin-left: 20px;"> Initials Name of individual health care provider </div> to discuss my health information with my attorney, or a governmental agency, listed here: _____ (Attorney/Firm or Governmental Agency Name)	
10. Reason for release of information: <input type="checkbox"/> At request of individual <input type="checkbox"/> Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

Date: _____

Signature of Patient or representative authorized by law.

* Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement *

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

Please Print Name

Signature

Date

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 acknowledgement An emergency situation

prevented us from obtaining acknowledgement Other (Please Specify)

Request / Refusal for Interpretation Services

California Language Assistance Program

California law requires that your insurance company provides interpretation services to help you speak with and understand your dentist and office staff.

Please fill out completely (check all that apply):

I need an interpreter

Yes, I need an interpreter to speak to my dentist and/or office staff

I prefer to speak the following language: _____

I do not need an interpreter

I do not need or want an interpreter.

I need an interpreter but I prefer to use my family, friend, and/or dentist office staff as an interpreter.

By signing below, I confirm that I have been offered an over- the- phone interpreter to help me speak with and understand my dentist and/or office staff.

Patient Name (please print): _____

Patient Signature: _____

Date: _____

Solicitud/rechazo de servicios de interpretación

Programa de asistencia de idioma de California

De acuerdo con la legislación de California, su compañía de seguros debe brindarle servicios de interpretación para ayudarle a comunicarse con su dentista y el personal del consultorio, y a comprender lo que le dice.

Llene el formulario completo (marque todas las opciones que correspondan):

Necesito un intérprete

- Sí, necesito un intérprete para comunicarme con mi dentista y/o el personal del consultorio.
- Prefiero hablar en este idioma: _____

No necesito un intérprete

- No necesito ni deseo un intérprete.
- Necesito un intérprete pero prefiero usar a un familiar, amigo y/o al personal del consultorio del dentista como intérprete.

Al firmar a continuación, confirmo que se me ha ofrecido un intérprete telefónico para ayudarme a comunicarme con mi dentista y/o el personal del consultorio, y comprender lo que me dicen.

Nombre del paciente (en letra de molde): _____

Firma del paciente: _____

Fecha: _____

要求 / 拒絕口譯服務

California 語言協助方案

California 法律規定，您的保險公司必須提供口譯服務，幫助您與牙醫和診所職員溝通並瞭解談話內容。

請完整填寫 (勾選所有適用項目)：

我需要口譯員

是的，我需要口譯員與我的牙醫和 (或) 診所職員溝通。

我想要說以下語言：_____

我不需要口譯員

我不需要或不想要口譯員。

我需要口譯員，不過我想要由我的家人、朋友和 (或) 牙醫診所職員擔任口譯員。

我在下面簽名即表示已由口譯員透過電話協助我與牙醫和 (或) 診所職員溝通並瞭解談話內容。

病患姓名 (請以正楷填寫)：_____

病患簽名：_____

日期：_____