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 alendrontate (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: To all **yes** responses, specify type of reaction.	Yes	No	DK
Local anesthetics _____	❑	❑	❑
Aspirin _____	❑	❑	❑
Penicillin or other antibiotics _____	❑	❑	❑
Barbituates, sedatives, or sleeping pills _____	❑	❑	❑
Sulfa drugs _____	❑	❑	❑
Codeine or other narcotics _____	❑	❑	❑
Metals _____	❑	❑	❑
Latex (rubber) _____	❑	❑	❑
Iodine _____	❑	❑	❑
Hay fever / seasonal _____	❑	❑	❑
Animals _____	❑	❑	❑
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	❑	❑	❑
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	❑	❑	❑
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	❑	❑	❑
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:

FAMILY DENTISTRY

HOME OF HISTORIC
"DOC" HOLLIDAYS'
DENTAL CHAIR

Richard Thomas, D.D.S.
Jared Ure, D.M.D.
102 Alabama St., Suite A
Crestview, FL 32536

HIPAA COMPLIANCE

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) this practice may use your personal health information for the purposes of treatment, payment, or healthcare operations only. The specific uses and disclosures that we intend to make are described in our Privacy Policy. You have the right to review our Privacy Policy prior to signing this consent form. You may request restrictions on the uses and disclosures described in the privacy policy by describing the requested restrictions in the "Restriction Request" section of this form.

CONSENT SECTION

I,_____, hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment, and healthcare operations. My signature below indicates that I have been given the opportunity to review the Privacy Policy of Richard Thomas, D.D.S. and Jared Ure, D.M.D., Family Dentistry. Please allow the following person(s) to obtain my healthcare information. (If none, please write NONE)

_____

_____

_____

RESTRICTION REQUEST SECTION

I hereby request the following restrictions on the use and disclosure of my health information. (Please describe in detail)

_____

_____

_____

_____

Patient Signature

Date

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CONSENT FORM

This undersigned authorizes Dr. Thomas/Dr. Ure to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Thomas/Dr.Ure to make a thorough diagnosis of the patient's dental needs. I also authorize Dr. Thomas/Dr. Ure to perform any and all forms of treatment, medication and therapy that may be indicted in connection with (name of patient)_____and further authorize and consent that Dr. Thomas/Dr.Ure choose and employ such assistance as he deems fit. I also understand payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered. In the event of default I (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of the note.

PATIENT_____DATE_____

PARENT/RESPONSIBLE PARTY_____

RELATIONSHIP TO PATIENT_____

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OFFICE POLICY

Thank you for choosing Dr. Richard Thomas and Dr. Jared Ure. Our policies are listed below for your careful review. These policies are intended to make your visit with us as pleasant as possible, and enable our staff to provide the highest quality of care.

Please read all information and acknowledge by signing below.

1. We ask that you present your insurance card at each visit. It is your responsibility to provide us with the correct information to bill your insurance.
2. If you have a change of address or telephone number(s), please notify our office immediately.
3. YOUR INSURANCE COVERAGE IS A CONTRACT BETWEEN YOU AND THE INSURANCE COMPANY. WHEN WE VERIFY YOUR COVERAGE ANY AMOUNT QUOTED TO US BY THE INSURANCE CO. IS NOT A GUARANTEE OF PAYMENT. It is very important that you understand the provisions of your policy.
4. We will collect your deductible, co-payment, or charge for a non-covered service at the time of your visit.
5. If your insurance denies our charges, or does not pay us in a timely manner, or if your account becomes delinquent (60 days) we reserve the right to refer your account to a collection agency to be reported to the credit bureau. A 1.5 % finance charge (18%) will be added to any balance over 60 days.
6. **For appointments that require 2 hours or more**: A 50.00 fee will be collected when you make the appointment to reserve this time for you. The $50.00 will be applied to your treatment fee at the time of appointment.
   If you do not show, or cancel without 24 hours notice, you will forfeit this fee.
7. **No show or missed appointments:** We understand there may be times when you are unable to keep an appointment, but we ask the courtesy of a phone call to cancel an appointment by you. If two appointments are missed without cancellation, you will be charged a $25.00 fee. If three appointments are missed, you will be dismissed from the practice for non-compliance.
8. **Unconfirmed appointments:** If you have not confirmed your appointment either by phone or text, we reserve the right to cancel your appointment.
9. Any balances on your account need to be paid in full before you will be seen again unless a payment arrangement has been made with billing personnel.
10. Returned checks will be subject to a Non-Sufficient Fund Fee of $35.00.

Please remember, whether you have insurance or not, you are ultimately financially responsible for payment of your charges. If you have any questions regarding our financial policy, please contact our office.

Thank you very much for reading and adhering to our policies.

I have read and have a full understanding of the financial policy of Dr. Richard Thomas and Dr. Jared Ure, Family Dentistry

Signature:_____ **Date:**_____