# Today’s Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PATIENT REGISTRATION

**PATIENT INFORMATION**

|  |  |  |  |
| --- | --- | --- | --- |
| **FIRST NAME**  |  **MIDDLE INITIAL**  | **LAST NAME**  | **NICKNAME OR PREFERRED NAME**  |
|  **E-MAIL** |
| **ADDRESS** | **BIRTHDATE**  |
|  **CITY**  |  **STATE**  | **ZIP**  | * **MALE  MARRIED**
* **FEMALE  SINGLE**
 |
| **HOME PHONE**  | **CELL PHONE**  | **WORK PHONE**  | **SOCIAL SECURITY NUMBER**  |

|  |  |  |
| --- | --- | --- |
| **IF PATIENT IS** **A MINOR,** **PROVIDE THE** **FOLLOWING**  | **PARENT/LEGAL GUARDIAN FIRST NAME LAST NAME**  | **RELATIONSHIP TO PATIENT** ** PARENT  GRANDPARENT  OTHER  LEGAL GUARDIAN**  |
| **EMAIL ADDRESS**  |
| **ADDRESS CITY STATE ZIP** ** SAME AS ABOVE**  |
| **HOME PHONE  PREFERRED**  | **CELL PHONE  PREFERRED**  | **WORK PHONE  PREFERRED**  | **SOCIAL SECURITY NUMBER**  |

**EMERGENCY CONTACT INFORMATION**

|  |  |  |
| --- | --- | --- |
| **EMERGENCY CONTACT PERSON**  | **PHONE NUMBER**  | **RELATIONSHIP**  |

**THE BIGGEST COMPLIMENT OUR PATIENTS CAN GIVE US IS THE REFERRAL OF FAMILY & FRIENDS**

|  |  |  |  |
| --- | --- | --- | --- |
| **WHOM MAY WE THANK FOR REFERRING YOU?**  |  **PROVIDE FULL NAME**  | **ARE THEY A PATIENT HERE?**  | * **YES**
* **NO – CHOOSE BELOW**
 |
| **HOW DID YOU HEAR ABOUT OUR OFFICE?** ** OUR WEBSITE  BUILDING SIGN**  | ** YOUR EMPLOYER**  | ** MAILER/UNION HALL  PUBLIC EVENT**  |
| ** INSURANCE COMPANY  ONLINE SEARCH**  | ** SOCIAL MEDIA**  | ** DENTAL CENTER EMPLOYEE**  |

## **Place a mark on “yes” or “no” to indicate if you have had any of the following:**

Bad breath □ Yes □ No Grinding teeth □ Yes □ No Sensitivity to heat □ Yes □ No

Bleeding gums □ Yes □ No Gums swollen or tender □ Yes □ No Sensitivity to cold □ Yes □ No

Blisters on Lips or mouth □ Yes □ No Jaw pain or tiredness □ Yes □ No Sensitivity to biting □ Yes □ No

Burning sensation on tongue □ Yes □ No Lip or cheek biting □ Yes □ No Sore or growth in mouth?

Chew on one side of mouth □ Yes □ No Loose teeth or broken fillings □ Yes □ No □ Yes □ No

Cigarette, pipe, or cigar smoking □ Yes □ No Mouth breathing □ Yes □ No How often do you floss?

Clicking or popping jaw □ Yes □ No Mouth pain, brushing □ Yes □ No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dry mouth □ Yes □ No Orthodontic treatment □ Yes □ No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fingernail biting □ Yes □ No Pain around ear □ Yes □ No How often do you brush?

Food collection between teeth □ Yes □ No Periodontal treatment □ Yes □ No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Foreign objects □ Yes □ No Sensitivity to sweetness □ Yes □ No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# PATIENT REGISTRATION

**ACKNOWLEDGEMENT & CONSENT**

**Acknowledgement of Insurance Payment Authorization**: I hereby authorize and direct payment of the dental insurance benefits otherwise payable to me for services rendered, directly to Emmy Dental. In the event that the insurance company misdirects payment to me, I understand that I am responsible to immediately remit such payments to Emmy Dental.

**Acknowledgement of Financial Responsibility**: I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. I further agree to inform Emmy Dental of any address or phone number change within 30 days of such a change. The necessary forms will be completed to help expedite insurance carrier payments as a courtesy to the patient. However, you are responsible for all fees, regardless of insurance coverage.

**HIPPA:** 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 (HIPPA). By signing this consent, I authorize you to use and disclose my protected health information to carry out:

* Treatment: Includes direct or indirect treatment by other healthcare providers involved in my treatment
* Obtaining payment from third party payers such as my insurance company
* The day-today healthcare operations of your practice.

I have been informed and given the right to review and secure a copy of your notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and rights under HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most accurate copy of this notice. I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operation, but that you are not required to agree to these restrictions. 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 revoked this consent is not affected.

**Authorization to Release Information:**  I hereby authorize Emmy Dental to furnish and /or release any information necessary to insurance carriers concerning my examination or treatment, to process my insurance claim acquired in the course of my examination or treatment, to allow a photocopy of my signature to be used to process my insurance claim. This order will remain in effect until revoked by me in writing.

**Missed Appointment Fee:** I understand that if I miss my appointment, and fail to give a 24-hour notice, I will be charged $25.00.

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PATIENT SIGNATURE DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PARENT/RESPONSIBLE PARTY SIGNATURE DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**RELATIONSHIP TO PATIENT**

**PATIENT NAME**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Although dental personnel primarily treat the area in and around your mouth, your mouth is 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Are you on a special diet? ⃝ Yes ⃝ No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Do you use tobacco? ⃝ Yes ⃝ No

**Women: Are you**

□ Pregnant/Trying to get pregnant?

□ Nursing?

□ Taking oral contraceptives?

 Do you use controlled substances? ⃝ Yes ⃝ No

**Are you allergic to any of the following?**

□ Aspirin □ Penicillin □ Codeine □ Acrylic □ Metal □ Latex □ Local Anesthetics

□ Other If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please check if you have, or have had, any of the following:**

□ AIDS/HIV Positive □ Cortisone Medicine □ Hemophilia □ Renal Dialysis

□ Alzheimer’s disease □ Diabetes □ Hepatitis A □ Rheumatic Fever

□ Anaphylaxis □ Drug Addiction □ Hepatitis B or C □ Rheumatism

□ Anemia □ Easily Winded □ Herpes □ Scarlet Fever

□ Angina □ Emphysema □ High Blood Pressure □ Shingles

□ Arthritis/Gout □ Epilepsy or Seizures □ Hives or Rash □ Sickle Cell Disease

□ Artificial Heart Valve □ Excessive Bleeding □ Hypoglycemia □ Sinus Trouble

□ Artificial Joint □ Excessive Thirst □ Irregular Heartbeat □ Spina Bifida

□ Asthma □ Fainting Spells/Dizziness □ Kidney Problems □ Stomach/Intestinal Disease

□ Blood Disease □ Frequent Cough □ Leukemia □ Stroke

□ Blood Transfusion □ Frequent Diarrhea □ Liver Disease □ Swelling of Limbs

□ Breathing Problem □ Frequent Headaches □ Low Blood Pressure □ Thyroid Disease

□ Bruise Easily □ Genital Herpes □ Lung Disease □ Tonsillitis

□ Cancer □ Glaucoma □ Mitral Valve Prolapse □ Tuberculosis

□ Chemotherapy □ Hay Fever □ Pain in Jaw Joints □ Tumors or Growths

□ Chest Pains □ Heart Attack/Failure □ Parathyroid Disease □ Ulcers

□ Cold Sores/Fever Blisters □ Heart Murmur □ Psychiatric Care □ Venereal Disease

□ Congenital Heart Disorder □ Heart Pace Maker □ Radiation Treatments □ Yellow Jaundice

□ Convulsions □ Heart Trouble/Disease □ Recent Weight Loss

Have you ever had any serious illness not listed above? ⃝ Yes ⃝ No

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Late Appointment or Cancellation Policy**

We strive to render excellent dental care to you and the rest of our patients. In an attempt to be consistent with this, we have a **Late Appointment or Cancellation Policy** that allows us to schedule appointments for all patients. When an appointment is scheduled, that time has been set aside for you and when it is missed, that time cannot be used to treat another patient.

Our policy is as follows:

We require that you give our office 24 hours’ notice in the event that you need to reschedule your appointment. This allows for other patients to be scheduled into that appointment. If you miss an appointment without contacting our office within the required time, this is considered a missed appointment. A fee of $25.00 will be charged to you; this fee cannot be billed to your insurance company and will be your direct responsibility. No future appointments can be scheduled nor can records be transferred without the payment of this fee.

Please note, if you are more than 15 minutes late, you might be asked to reschedule unless the doctor’s schedule can still accommodate you. Priority will be given to the patients who arrive on time and you might have to be worked in between them. This may mean you will have a long wait. If this is not convenient for you, you may choose to reschedule.

 I have read and understand the Late Appointment or Cancellation Policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Print Patient Name Date**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Signature**