

Patient Registration

Patient Name					
Patient Number	ABC	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Birthdate	Age	Today's Date
Home Address			City	State	Zip
Please Check One: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Widow		Occupation			
Email Address		Cell Phone Number		Home Phone Number	
Your Employer		How Long Employed	Your Soc Sec. #	Work Phone	
Are you a full time student? <input type="checkbox"/> Yes <input type="checkbox"/> No		<i>If patient is minor we need Mother's Birth Date and Father's Birth Date:</i>			
Person responsible for account			Driver's license number		
Name of spouse (Parent if minor)			E-mail address	Cell Phone	
Spouse's (parent's) employer		Spouse's Soc. Sec. #		Work phone	
How did you hear about our office?			EMERGENCY INFORMATION Name, Address, & telephone of a relative not living with you.		
Reason for this visit					

Dental Insurance Information

DENTAL INSURANCE INFORMATION (Primary Carrier)		
Insured's name	DOB	SS#
Insured's employer		
Insurance Co		
Insurance Co Address		
Phone #		
Group #		Local #

Dental History

Please check any of the following problems that apply to you.

- Sensitivity (hot, cold, sweet)
Where? UR LR UL LL
- Headaches, earaches, neck pain
- Jaw joint pain
- Teeth or fillings breaking
- Grinding or clenching teeth
- Bleeding, swollen or irritated gums
- Loose, tipped or shifting teeth
- Bad breath

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

- Dentures
- Partial dentures
- Braces
- Periodontal (gum) treatments

Please share the following dates:

Your last cleaning _____ / _____
 Your last oral cancer screening _____ / _____
 Your last complete X-Rays _____ / _____

Name of Previous Dentist _____

City _____ State _____

Phone Number _____

What is the most important thing to you about your future smile and dental health?

If you could whiten your teeth for a cost anyone could afford, would you do it? Yes No

Do you smoke or use chewing tobacco?

How much? _____ For how long? _____

If I could change my smile, I would:

- Make them whiter
- Make them straighter
- Close spaces
- Replace black metal fillings with tooth colored restorations
- Repair chipped teeth
- Replace missing teeth
- Replace old crowns that don't match
- Have a smile makeover

On a scale of 1 -10, with 10 being the highest rating:

How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

Where do you want your dental health to be?

1 2 3 4 5 6 7 8 9 10

Why did you leave your previous dentist?

What is the most important thing to you about your dental visit today?

Medical History

Please check any of the following that apply to you:

- | | | | |
|-------------------------------------------------|-----------------------------------------------------|-------------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Allergies (Seasonal) | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Jaw Joint Pain | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fainting | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Heart Conditions | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Lesions (Congenital) | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Nervousness/Depression | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Periodontal Disease | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Phen Fen (1 month +) | <input type="checkbox"/> Venereal Diseases |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Pregnant Currently | <input type="checkbox"/> Other |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Radiation (head/neck) | |

Do you have any of the following drug allergies?

- | | |
|-------------------------------------------|----------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Nitrous Oxide |
| <input type="checkbox"/> Percodan | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Local Anesthetic | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Valium |
| <input type="checkbox"/> Darvon | <input type="checkbox"/> Other |
| <input type="checkbox"/> Erythromycin | |

Are you under a physician's care? What for?

Are you taking any medications? What?

Family Physician _____

Phone Number _____

Print Name: _____ Is there any other medical or dental information we should know about? _____

Signature (Patient or Guardian) _____ Date _____ Dentist Signature _____

Financial Policy

Thank you for choosing our office as your dental health care provider. We are committed to providing you with the highest quality lifetime dental care, so that you may fully attain optimum oral health. Please understand that payment of your bill is considered part of your treatment.

Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, and Discover. Outside financing is available upon request and approval.

Please check if you would like more information about financing options.

Please Note: Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance; you will be responsible for any collection and/or legal charges incurred.

Do You Have Insurance?

- As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible.
- All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Our office is not a party to that contract.
- Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.
- We ask that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance company, by cash, check, MasterCard, Visa or Discover at the time we provide the service to you.
- Insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our financial policy.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO MY DENTAL OFFICE.

Signature _____ Date _____
(Patient or Guardian)

Payments for all office visits are expected on the same day of service. Any other arrangements must be made in advance and those arrangements will carry an interest charge of 18.00% per annum (1.5% per month). I/we hereby authorize any insurance company, group plan, organization, employer or provider of service to release, prior to or after payments, any and all information, related to this claim. I/we hereby authorize any and all payments from any insurance group for the dental service provided to go directly to the dental office of Create-A-Smile, P.C. I/we understand that the submission of any and all insurance claims by this dental office is done solely as a courtesy and that I am/we are ultimately responsible for the submission of all dental charges to the insurance group(s).

In consideration of dental services furnished by the dental office of Create A Smile PC to the above-named maker(s) and their authorized family members, I/we hereby guarantee payment in full of said account in accordance with the credit terms set by Create A Smile PC. In the event of default of said account when due, the entire balance shall become due and payable immediately without notice at the election of the payee hereof. The maker(s) specifically agree that in the event of default, reasonable attorney's fees and reasonable cost of collection shall be added to the amount due on this account. The maker(s) hereof jointly and severally waive presentment of payment, protest, notice of protest and notice of non-payment on this account.

THIS OFFICE WILL CHARGE \$50.00 FOR EACH MISSED APPOINTMENT OR A CANCELLED APPOINTMENT WITH LESS THAN TWO BUSINESS DAYS NOTICE.

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. The Health Insurance Portability & accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As Required by HIPPA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information. We may contact you to provide appointment reminders of information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization. You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer.

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. This notice is effective as of **April 14, 2003** and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office. You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaints with our office, or with the department of Health & Human Services, about violations of the provisions of this notice.

We will not retaliate against you for filing a claim.

Patient Name _____ (Please Print)
Date _____ Signature (Patient or Legal Guardian if Minor)