Rogersville FAMILY DENTAL

PATIENT REGISTRATION

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

Preferred Name: _____

Address: _____ City/State/Zip Code: _____

Home Phone #: (____) _____

Birth Date: _____/_____/_____ Social Security Number: _____

Emergency Contact Name & #: _____ (____) _____

Sex:	Marital Status:
☐ Male ☐ Female	☐ Married ☐ Single ☐ Widowed

Responsible Party (if someone other than the patient)

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

Address: _____ City/State/Zip Code: _____

Home Phone #: (____) _____ Birth Date: _____/_____/_____ Soc Sec: _____

Primary Insurance Information	**Secondary Insurance Information**
Subscriber Name: _____	Subscriber Name: _____
Subscriber ID/SSN: _____	Subscriber ID/SSN: _____
Subscriber DOB: _____/_____/_____	Subscriber DOB: _____/_____/_____
Relationship to Patient:	Relationship to Patient:
☐ Self	☐ Self
☐ Spouse	☐ Spouse
☐ Child	☐ Child
☐ Other	☐ Other
Employer: _____	Employer: _____
Insurance Company: _____	Insurance Company: _____
Insurance Co Ph #: (____) _____	Insurance Co Ph #: (____) _____
Group Number: _____	Group Number: _____

Rogersville Family Dental 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 using.

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

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

Are you allergic to any of the following?

❑ Aspirin ❑ Penicillan ❑ Codeine ❑ Acrylic

❑ Metal ❑ Latex ❑ Sulfa Drugs ❑ Local Anesthesia

❑ Other? If Yes: _____

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

AIDS/HIV Positive ❍ Yes ❍ No	Cortisone Medicine ❍ Yes ❍ No	Hemophilia ❍ Yes ❍ No	Radiatiom 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
Arthrits/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 Problems ❍ 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	Tonsilitis ❍ 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 If Yes: _____

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:

X **Date:** _____

ROGERSVILLE FAMILY DENTAL

I understand that, under the Health Insurance POrtability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information will be used but not mandatory for me to sign in order to :

1. **Conduct, plan and direct my treatment and follow up among the multiple health care providers who may be involved in that treatment directly or indirectly.**
2. **Obtain payment from third party payers**
3. **Conduct normal healthcare operations such as quality assessments and physician certifications.**

I have been informed by this office of the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given a copy of this office's Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Privacy Practices from time to time and that I may contact this organization at any time at the above address to Obtain a current copy.

I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that this organization is not required to agree to my request restrictions, but if this organization does agree, then said organization is bound by such restrictions.
I, hereby understand that I may revoke this consent in writing at any time except to the extent this organization may have taken action relying on this consent.

Patient Name_____

Signature_____

Relationship to Patient_____

Date_____

Insurance and Payment Disclaimer

- **Payment for professional services is due at the time dental treatment is provided. Every effort will be made to provide a treatment plan that fits your timetable, budget, and gives you the best possible care.**

  A 7% discount for payment in full at time of service with ash and 5% discount for credit or debit card will be provided for our patients with no dental insurance coverage for amounts over $500. We are also excited to be able to provide third party financing through Care Credit, offering interest free financing for 6 or 12 months *if Care Credit is used, a discount will not be applied.

- **Insurance is submitted for your convenience. We will submit charges for dental work to your insurance company as long as we have received all the needed information on the day of your appointment. It is very important that you be familiar with your insurance benefits. We will collect payment from you based on the estimated amount that your insurance is not expected to pay. By law your insurance company is required to pay/respond to each claim within 30 days of receipt. We file all insurance electronically so your insurance company should receive each claim within days of treatment.**

- **You are responsible for any balance on your account after 90 days, whether insurance has paid or not. We will be glad to send a refund to you once insurance has issued us payment.**

I (please print) _____, have read and understand the above statements regarding the insurance and payment policy for Rogersville Family Dental.

Signature_____ Date: _____

HIPAA Medical Information Release Form

Name: _____ Date of Birth:_____

Release of Information

Please put the fist and last name of the person/people you wish to release information to.

☐ **I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:**

- **Spouse _____**
- **Child_____**
- **Other_____**

☐ **DO NOT RELEASE INFORMATION TO ANYONE**

This release of information will remain in effect until terminated by me in writing.

If unable to reach me (PLEASE CHECK ONE BOX):

☐ You may leave me a detailed message.

☐ Please leave a message asking me to return your call

Signed:_____ Date: ____/_____/____