New Patient Registration

Date:____/____/____

Patient Information

PATIENT FIRST NAME:_____ **LAST:**_____ **INITIAL:**_____

DOB:____/____/____ SS#:_____-_____-_____ Sex: Male: ☐ Female: ☐

Address:_____City:_____State:_____Zip:_____

Cell:(_____)_____-_____ Work:(_____)_____-_____ Home:(_____)_____-_____

Marital Status: Single: ☐ Married: ☐ Divorced: ☐ Widowed: ☐ Separated: ☐

Email:_____

Employer:_____Spouse's Employer_____

Employment Status: Full Time: ☐ Part Time: ☐ Retired: ☐ Student: ☐

IN CASE OF AN EMERGENCY CONTACT:

Emergency Contact:_____ Phone:(_____)_____-_____

Dental Insurance

Dental Insurance : Yes: ☐ No: ☐ Insurance Company_____

Relation to Subscriber: Self:☐ Spouse:☐ Dependent:☐

If not self, Subscriber name:_____ DOB:____/____/____

Employer:_____ Subscriber SS#:_____-_____-_____

Secondary Insurance:Yes:☐ No:☐ Insurance Company_____

Relation to Subscriber: Self:☐ Spouse:☐ Dependent:☐

If not self, Subscriber name:_____ DOB:____/____/____

Employer:_____ Subscriber SS#:_____-_____-_____

Assignment and Release:
I authorize release of any information relating to all dental claims an understand that I am responsible for all costs of dental treatment regardless of my insurance coverage.

Signed_____Date:____/____/____

Dental History

Reason for today's visit: Cleaning:☐ Exam:☐ Tooth Pain:☐ Other:☐_____

How often do you brush?: 1x/day: ☐ 2x/day:☐ 3+/day:☐ Never:☐

How often do you floss?: 1x/day:☐ 1x/week:☐ 1x/month:☐ Never:☐

Date of last dental visit_____

Questions or Concerns for the doctor: None:☐ _____

Mark ☒ if you have had any of the following:

Bad Breath	☐	Food collection between teeth	☐	Orthodontic treatment	☐
Bleeding gums	☐	Grinding teeth	☐	Pain around ear	☐
Blisters on lips	☐	Gums swollen/tender	☐	Periodontal treatment	☐
Burning sensation on tongue	☐	Jaw pain/tiredness	☐	Sensitivity to cold	☐
Chew on one side	☐	Lip or cheek biting	☐	Sensitivity to heat	☐
Cigarette/Pipe/Cigar smoking	☐	Loose teeth/broken filling	☐	Sensitivity to sweets	☐
Clicking/Popping jaw	☐	Mouth breathing	☐	Sensitivity when biting	☐
Dry mouth	☐	Mouth pain	☐	Sores/growths in mouth	☐
Fingernail biting	☐				

Medical History

Mark Yes☒ or No☒ if you have had any of the following:

AIDS/HIV	Yes☐ No☐	Epilepsy	Yes☐ No☐	Radiation Treatment	Yes☐ No☐
Anemia	Yes☐ No☐	Fainting/Dizziness	Yes☐ No☐	Respiratory Disease	Yes☐ No☐
Arhritis	Yes☐ No☐	Glaucoma	Yes☐ No☐	Rheumatic Fever	Yes☐ No☐
Artificial Heart Valve	Yes☐ No☐	Headaches	Yes☐ No☐	Scarlet Fever	Yes☐ No☐
Artificial Joint	Yes☐ No☐	Heart Murmur	Yes☐ No☐	Shortness of Breath	Yes☐ No☐
Asthma	Yes☐ No☐	Heart Problems	Yes☐ No☐	Sinus Trouble	Yes☐ No☐
Back Problems	Yes☐ No☐	Hepatitis Type_____	Yes☐ No☐	Skin Rash	Yes☐ No☐
Bleeding abnormally	Yes☐ No☐	Herpes	Yes☐ No☐	Special Diet	Yes☐ No☐
Blood Disease	Yes☐ No☐	High Blood Pressure	Yes☐ No☐	Stroke	Yes☐ No☐
Cancer	Yes☐ No☐	Jaundice	Yes☐ No☐	Swollen Feet/Ankles	Yes☐ No☐
Chemical Dependency	Yes☐ No☐	Jaw Pain	Yes☐ No☐	Swollen Neck Glands	Yes☐ No☐
Chemotherapy	Yes☐ No☐	Kidney Disease	Yes☐ No☐	Thyroid Problems	Yes☐ No☐
Circulatory Problems	Yes☐ No☐	Liver Disease	Yes☐ No☐	Tonsilitis	Yes☐ No☐
Congenital Heart Lesions	Yes☐ No☐	Low Blood Pressure	Yes☐ No☐	Tuberculosis	Yes☐ No☐
Cortisone Treatments	Yes☐ No☐	Mitral Valve Prolapse	Yes☐ No☐	Tumor on neck/head	Yes☐ No☐
Cough	Yes☐ No☐	Nervousness	Yes☐ No☐	Ulcer	Yes☐ No☐
Diabetes	Yes☐ No☐	Pacemaker	Yes☐ No☐	Venereal Disease	Yes☐ No☐
Emphysema	Yes☐ No☐	Psychiatric Care	Yes☐ No☐	Weight Loss	Yes☐ No☐

Women:

Pregnant:Yes: ☐ No: ☐ Due Date:____/____/____ Nursing:Yes:☐ No:☐ Taking oral contraceptives:Yes:☐ No:☐

Medications

Are you taking any medication? Yes: ☐ No: ☐

List of Medications: _____

_____

_____

_____

_____

Have you ever used a bisphosphonate:(Fosamax, Actonel, Atelvia, Didronel, Boniva, Prolia):Yes:☐ No:☐

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionian, Adipex, Fastin, Pondimin and Redux :Yes:☐ No:☐

Preferred Pharmacy_____**Location**_____

Allergies

Mark ☒ on any known allergies:

Latex	☐	Barbiturates	☐
Penicillin	☐	Aspirin	☐
Sulfa	☐	Codeine	☐
Local Anesthetic	☐	Other	☐
Iodine	☐	_____	

Other

How did you hear about our office?

Referral ☐ Referrer_____

Mailer ☐

TV ☐

Radio ☐

Insurance☐

Other ☐ _____

FINANCIAL AGREEMENT FOR THE OFFICE OF SOUTHWEST DENTAL CENTER

This agreement is to inform you of your financial obligation to our practice. We are committed to providing you with the most comprehensive dental care using only the highest quality materials and technology available in the market today. We are also committed to providing you with up-to-date information and educational tools so that you may fully participate in maintaining optimum oral health. This financial agreement is intended to facilitate our ability to provide excellent service to you while minimizing our administrative costs.

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 an agreement between you, your employer, and the insurance company. Our practice is not a party to that agreement. If payment from your insurance company is not received within 60 days from date of service, you will be expected to pay the balance in full. I agree to pay 18% interest on any balance unpaid, or becomes delinquent, in addition to court costs, and reasonable attorney's fees.

As a courtesy to you we will help you process all your insurance claims. You may direct your insurance company to pay your benefits directly to our practice by signing the authorization on the Assignment of Benefits Agreement. In order for our practice to file your insurance claim, you must bring in a completed dental insurance form or proof of insurance at each appointment.

Your **estimated** copayment for treatment, which is the amount not covered by your insurance, is due at the time treatment is provided. Your **estimated** copayment may be adjusted after the time of treatment depending upon the final reconciliation of insurance payments. Our practice accepts cash, personal checks, MasterCard, Visa, and Discover. Extended payment financing is available upon request and approval.

Please do not hesitate to ask if you have any questions regarding this financial agreement. We are committed to providing you with the ultimate experience in dental care.

_____

Print Name of Patient or Responsible Party

_____ _____

Signature of Patient or Responsible Party Date

SOUTHWEST
DENTAL CENTER

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activity, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including revisions of our Notice, at any time by contacting Southwest Dental Center.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us a written notice of your revocation submitted to Southwest Dental Center. Please understand that the revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

☐ **REVOCATION OF CONSENT**

I revoke my Consent for use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form. I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT. Include completed Consent in patients chart.

PLEASE CHECK ALL THAT APPLY

☐ **You may disclose information to my family members and or non-family members. Please list name, phone number, and relationship.**

NAME	PHONE NUMBER	RELATIONSHIP

☐ **You may leave Protected Health Information on my answering machine/ voicemail.**

Home Phone #: _____ Cell Phone #: _____

Name of Patient: _____

Signature: _____ Date: _____