PATIENT REGISTRATION

ID: _____ Chart ID: _____

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

Patient Is: ☐ Policy Holder Preferred Name: _____

☐ Responsible Party

Responsible Party (if someone other than the patient)

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

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

◯ Responsible Party is also a Policy Holder for Patient ◯ Primary Insurance Policy Holder ◯ Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ State / Zip: _____ _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ◯ Male ◯ Female Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic: _____

E-mail: _____ ☐ I would like to receive correspondences via e-mail.

Section 2 Section 3

Employment Status: ◯ Full Time ◯ Part Time ◯ Retired

Student Status: ◯ Full Time ◯ Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

Additional Comments:

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ◯ 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: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ◯ 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: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

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 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 _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you

Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: _____

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

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation 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
Arthritis/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 Problem ◯ 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	Tonsillitis ◯ 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 _____

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 _____

Supplemental Medical History Form Questions:

Do you have a congenital heart defect that has not been repaired? No Yes _____

Have you had a heart valve replacement of any type? No Yes _____

Have you ever had infective endocarditis? No Yes _____

Has an orthopedic surgeon told you that you need antibiotics before dental treatment because you have had a joint replacement, pins, or other joint repair? No Yes_____

So that we may provide the best care possible, are there any special needs conditions that have not already been listed, including Autism, Cognitive Impairment, chromosomal conditions or syndromes?

No Yes _____

If you are in a wheelchair, can you easily move to our dental chair for treatment? No Yes N/A
We are able to accommodate you in your wheelchair in specially designed rooms in our sedation center.

Office Protocol Regarding Dental Treatment of Children

We treat patients of all ages, and recommend an introductory visit beginning at about age 6 months, when the first primary teeth appear. We want to get your child off to a healthy start!

Our office follows the recommendations and protocols of the American Dental Association and the American Academy of Pediatric Dentistry. While we always have an assistant in the room who also serves as a chaperone, we do not have parents in the treatment room during actual treatment. Dental treatment involves instruments and equipment that is sharp and/or spinning at 400,000 rpms. Even well-intentioned parents inadvertently cause distraction at critical moments, which can result in injury. An exception is the introductory and cleaning appointments under age 3, where the child will sit on your lap. We will take excellent care of your child.

We will involve you in the treatment-planning process, we encourage questions, and we will keep you informed of any issues that arise during treatment. In some cases, based on anxiety and cooperation levels, extent of treatment needed, or medical conditions, we might recommend treatment under some form of sedation. All of our decisions are made with your child's dental and overall health in mind.

I have answered questions to the best of my knowledge, and understand and agree to the office policies that have been communicated to me.

_____ _____

Patient, parent, or guardian signature date

CONCORD DENTAL

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____ _____, have received a copy of this office's Notice of Privacy Practices.

{Please Print Name}

{Signature} {Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- □ Individual refused to sign
- □ Communications barriers prohibited obtaining the acknowledgement
- □ An emergency situation prevented us from obtaining acknowledgement
- □ Other (Please Specify)

Financial Arrangements and Dental Insurance

We are committed to providing you with the best possible care. If you have dental insurance, we want to help you receive the maximum benefits under the policy. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

Payment is due when services are rendered unless other arrangements are made. We accept cash, checks, MasterCard/Visa, American Express, and Discover Card. There will be a $35.00 charge for each returned check. Treatment involving laboratory work, such as dentures and crowns, requires half the fee when we start and the balance at delivery. A minimum charge of $45.00 will be made for broken appointments cancelled without 48 hours notice. If you indicate that someone else is responsible for the cost of your treatment, please remember that ultimately you are responsible for any unpaid balance.

In most cases we will accept assignment of insurance benefits. Dental benefit plans vary in the amount of coverage they provide, with some covering a high percentage and a wide range of treatment, while others cover lower percentages and fewer procedures. Keep in mind that many pay according to a fee schedule, which might have no relationship to the fees in this area. Remember that the insurance contract is between you (or your employer) and the insurance company; we are not a party to that contract and the responsibility is between you and our office. When we accept assignment of benefits, we are not agreeing to a reduced fee, we are simply allowing that portion of the fee your insurance covers to be paid directly to us by your insurance company. We will estimate your share, including any deductible, based on our experience with your policy, and this amount is due at the time of service. If we do not receive the insurance payment within 60 days, the full balance will be due and payable by you. Any balance over 60 days will incur financial charges at a rate of 1.5% per month with a minimum finance charge of $1.00.

The type of treatment we recommend is based on our professional judgment, not on what your dental benefits cover. We do not believe that it is in your best interest to compromise your treatment in order to accommodate your insurance benefits, which might be less than optimal. Dental benefits are not designed to delineate your treatment needs, but rather to assist you in the cost of treatment. We understand that insurance coverage might play a part in your treatment decisions, but we will recommend what is best for you regardless of insurance coverage. We are happy to discuss the treatment plan with you, thus involving you, rather than your insurance company, in the decision. For patients wishing to make extended payments, we offer a third –party financial option. Care Credit financing may allow low monthly payments for qualified applicants. Alternatively, we will in some cases agree to bill your credit card a set monthly amount. We cannot, however, offer credit to persons unable or unwilling to meet the above options. When granting any credit, we may, at your option, run a credit report in accordance with applicable laws.

I have read and agree to the above payment policy.

Responsible Party_____Date_____

I hereby authorize insurance payment directly to Concord Dental for dental work in their office.

Responsible Party_____Date_____

Concord Dental, L.L.C.

HIPAA AUTHORIZATION FOR DISCLOSURE OF
PROTECTED HEALTH INFORMATION
In compliance with the HIPAA Privacy Rule

PATIENT INFORMATION

Patient's Name:_____

Date of Birth: _____

I, the above named patient, give my consent to release ALL my Protected Health Information (including: Account & Payment Info, Insurance, Appointments, Test Results & X-Rays, Care and Treatment) **by any of the following methods** (but not limited to written, photocopy, paper, electronic formats, verbal, fax) **to the following parties:**

1.Name _____ Relationship: _____

2.Name _____ Relationship: _____
(If more space is required, please let us know)

****I DO NOT** WISH ANY INFORMATION TO BE RELEASED Signature_____

I understand that I have the right to revoke this authorization at any time, and that my revocation must be in writing. I understand that the revocation does not apply to information that has already been released in response to this authorization.

I understand that any disclosure of information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I may inspect and/or copy the information to be disclosed. If I have any questions about disclosure of my health information, I may contact the privacy officer to request a copy of this authorization. I understand that I need not sign this authorization to assure treatment, and authorizing this disclosure is voluntary.

I understand that my health record may include information pertaining to the treatment of drug and alcohol abuse, mental illness, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), sexually transmitted diseases, tuberculosis, hepatitis C or genetics.

A photocopy and/or facsimile of this authorization shall be considered as true and valid as the original.

_____ _____
Signature of Patient (Parent or Guardian) Date

_____
Printed Name