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

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.: _____

Section 3

Referred By: _____

Previous Dentist: _____

Emergency Contact: _____

Emergency Contact #: _____

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	
Are you on a special diet?	Yes	No	
Do you use tobacco?	Yes	No	
Do you use controlled substances?	Yes	No	
Do you need to pre-medicate?	Yes	No	If yes, please explain: _____

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 Acrylic Metal Latex Local Anesthetics

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	Renal Dialysis	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Rheumatic Fever	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Rheumatism	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Scarlet Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Shingles	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	Hives or Rash	Yes	No	Sickle Cell Disease	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hypoglycemia	Yes	No	Sinus Trouble	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Irregular Heartbeat	Yes	No	Spina Bifida	Yes	No
Asthma	Yes	No	Fainting Spells/Dizziness	Yes	No	Kidney Problems	Yes	No	Stomach/Intestinal Disease	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Leukemia	Yes	No	Stroke	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Liver Disease	Yes	No	Swelling of Limbs	Yes	No
Breathing Problem	Yes	No	Frequent Headaches	Yes	No	Low Blood Pressure	Yes	No	Thyroid Disease	Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Lung Disease	Yes	No	Tonsillitis	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Mitral Valve Prolapse	Yes	No	Tuberculosis	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Pain in Jaw Joints	Yes	No	Tumors or Growths	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Murmur	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disorder	Yes	No	Heart Pace Maker	Yes	No	Radiation Treatments	Yes	No	Yellow Jaundice	Yes	No
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Recent Weight Loss	Yes	No			

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 _____

BLACKMAN GROVE
DENTAL

Dismissal Agreement

I **understand** that it is my responsibility to provide a 48 hour notice to cancel or change an appointment. I **understand** that this gives Blackman Grove Dental ample time to fill my appointment. I **understand** that if I am unable to give this notice I will be considered a NO SHOW. I **understand** that after 2 NO SHOW appointments I will be dismissed from the practice.

X

Signature

BLACKMAN GROVE
DENTAL

Financial Statement

I understand that I am responsible for the entire cost of treatment. I further understand that if it ever becomes necessary for this account to be turned over for collection, I am responsible for any collection and / or attorney fees.

Insurance Statement

I authorize the release of any information needed to process my insurance claims. I further understand that I am responsible for the entire cost of treatment regardless of insurance coverage or payments. I authorize payment of insurance benefits directly to the dentist otherwise payable to me.

Acknowledgement of Receipt of Privacy Practices Notice

I hereby acknowledge that I have seen a copy of Privacy Practices Policy located in the lobby. I have also declined a copy of the Practice Privacy Policy.

Signature of Patient or Responsible Party

Blackman Grove Dental

Dental Treatment Consent

PATIENT NAME (please print) _____ _____ DATE _____

I hereby give consent and authorize the dentist and/or team member of Blackman Grove Dental to take any x-rays, study models, intra-oral photos or any other aids deemed appropriate to make a thorough diagnosis of my dental needs. I also give consent and authorize the dentist to perform any and all recommended forms of treatment mutually agreed upon by the doctor and myself. I consent to the use of the appropriate topical medications, anesthetics and therapy that may be indicated in my treatment. I understand that there may be certain risk when using local anesthetic agents or nitrous oxide if needed. Furthermore, I consent and authorize that the doctor choose and employ such assistance as deemed fit to provide the recommended treatment.

PATIENT SIGNATURE _____

PATIENT AUTHORIZATION FORM

This authorization sets forth your right to use or disclose my protected health information as specified below for the purposes and parties as designated below.

Description of specific information authorized:

_____

_____

_____

_____

Description of the specific purposes for use and disclosure:

_____

_____

_____

_____

Parties requesting information and authorized to use and disclose the information:

_____

Parties to whom information may be disclosed:

_____

I reserve the right to:

- Revoke this authorization in writing by submitting it to the attention of your Privacy Officer;
- Inspect or copy the protected health information to be used or disclosed;
- Refuse to sign this authorization knowing that you will not condition treatment or payment on my providing this authorization (except for research related treatment).

I understand that information used or disclosed pursuant to this authorization may be subject to additional disclosure by the recipient and no longer protected by HIPAA.

You will receive compensation from a third party for the use or disclosure of my information:
Yes or No

This authorization is effective from _ day of_____, 20____until _____ day of____, 20___.

Print Patient Name:_____
Relationship (if other than patient):_____
Signature: _____

Practice Name:_____

Address: _____

City/State/Zip:_____