PATIENT REGISTRATION

Patient Information

First Name _____ Last Name _____ Middle Initial _____ Suffix _____

Patient is _____Responsible Party _____Policy Holder Preferred Name _____

Address: _____ City_____ Zip_____

Home Phone _____ Cell Phone _____ Work Phone _____

Birth Date _____ Age _____ M/F _____ Social Security Number _____

Marital Status (S/M/D/W) _____ Spouse Name _____ Spouse Date of Birth _____

Email _____ May we contact you via email/text? _____ Occupation _____

Employed By _____ Employer Address _____

Are You A Student? (Y/N) _____ Full Time/Part Time _____Name of School _____

Emergency Contact _____ Relationship to Patient _____

How did you hear about us? _____

Responsible Party (if other than patient)

First Name _____ Last Name _____ Middle Initial _____ Suffix _____

Address: _____ City_____ Zip_____

Birth date _____ Social Security Number _____ Relationship to Patient _____

Insurance Information (please provide a copy of your card)

Name of Insured _____ Dental Insurance Company_____

Employed by _____ Employer Address _____

Policy number _____ Group Number _____ Insured Social Security Number _____

Centerville Family Dental, Ltd. does not discriminate on the basis of race, color, national origin, age, disability or sex.

I authorize the dentist and dental staff to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize the release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I authorize the release of any information concerning my (or my child's) health care, advice and treatment to another dentist for referral.

I hereby authorize payment of insurance benefits directly to Centerville Family Dental, Ltd. I understand that my dental insurance carrier may pay less than the actual bill for services. I understand I am financially responsible for payment in full on all accounts.

I have received and have read this office's Notice of Privacy Practices

Signature _____ Date _____

MEDICAL HISTORY

Physician's Name _____ Date of Last Physical _____
Do you have any artificial joints, heart valves or spinal/neck fusion? _____
Are you on blood thinners? _____ Are you taking bisphosphonates for osteoporosis? _____
Have you had any recent illnesses, hospitalizations or surgeries? _____
_____
Do you have allergies to aspirin, antibiotics or other medications? _____
List all medications you are taking at this time _____
_____
Have you ever reacted adversely to dental treatment? _____
(Women) Do you suspect you are pregnant? _____ Are you nursing? _____ Oral contraceptives? _____
When was your last dental appointment? _____ Previous dentist's name? _____

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		

DENTAL HISTORY

(Please circle Y or N)

Do your gums bleed while brushing or flossing? Y/N
Are your teeth sensitive to hot or cold liquids/food? Y/N
Are your teeth sensitive to sweet or sour liquids/food? Y/N
Do you feel pain in any of your teeth? Y/N
Do you have any sores or lumps in or around you mouth? Y/N
Have you had any head, neck or jaw injuries? Y/N
Have you had orthodontic (braces) work? Y/N
Do you experience dry mouth? Y/N
Have you had your wisdom teeth removed? Y/N

Have you ever experienced the following jaw problems?
Clicking Y/N
Pain (joint, ears, face) Y/N
Difficulty in opening or closing Y/N
Difficulty in chewing Y/N
Do you clench or grind your teeth? Y/N
Have you ever seen a gum specialist? Y/N
Do you use tobacco products? Y/N
Do you experience dental anxiety? Y/N

To the best of my knowledge I have answered the questions on this form accurately. I understand incorrect information could be dangerous to my health. It is my responsibility to inform Centerville Family Dental, Ltd. of any change in my medical status.

Signed (Patient, Parent or Guardian) _____ Date _____

For office use only Medical History Reviewed _____ Date _____

Centerville Family Dental, LTD- Patient Communication Consent

I wish to be contacted in the following manner (check all that apply)

Home ☐ Cell ☐
☐ OK to leave message with detailed information
☐ Leave message with call-back number only
☐ OK to give information to individual(s) listed below

Work Phone ☐
☐ OK to leave message with detailed information
☐ Leave message with call-back number only

Written Communication ☐
☐ OK to mail to my home address
☐ OK to fax

The following individual(s) may be contacted to discuss my medical care if necessary:

Name(s)	Relationship	Phone
1.		
2.		
3.		

This information will be considered current & valid unless otherwise notified
Patient/Legal Guardian Signature: _____
Printed Name: _____ Date: ___/___/___

Centerville Family Dental, LTD - Financial Policy & Agreement

Thank you for choosing Centerville Family Dental, LTD. Our team is dedicated to providing high quality care to restore and maintain your dental health. If you have any questions regarding our financial policy, please do not hesitate to ask.

A STATE ISSUED PHOTO ID (such as a driver's license) and INSURANCE CARD (or digital insurance card) must be presented the day of your visit and will be scanned into your chart for our records. This will allow us to assist you with submission of any dental insurance claims.

IN/ OUT OF - NETWORK INSURED PATIENTS: Insurance coverage is a benefit of the patient not our facility. It is your responsibility to know the specifics of your insurance policy. As a courtesy to our patient's, we will obtain information available regarding your plan coverage and will provide you with a Pre-treatment ESTIMATE of your expected out of pocket cost for any recommended treatment plan. Our estimate will be as accurate as possible. Please understand that fees paid by your insurance company are according to their own fee schedule, not necessarily the actual fees and cost of treatment performed by our office. Any estimated out of pocket co-pay will be collected at the time of service. Unfortunately, we may not be aware of your specific plan limitations. This may result in a payment that differs from our actual cost of treatment.

Fees resulting from plan limitations and exclusions are the patient's responsibility and include items such as but not limited to: Missing tooth clause, procedures which are not a benefit of coverage, inaccurate information received from the patient, annual maximum of benefits being reached, changes or termination of coverage.

Please **initial** that you have read and understand the above statement _____ **initials.**

Self-Pay Patients: For patients without dental insurance, payment is required at the time of service.

Payment Options:

- You may choose to pay by cash, check, or credit card. We accept Visa, MasterCard, American Express, and Discover.
- We also participate with Care Credit (carecredit.com). They offer several financing options.

Missed Appointment Fee: Our office makes every effort to schedule appointment at your convenience and confirm your appointment in advance. We do require a 24 hour notice if you are unable to keep your appointment. If you FAIL TO MAKE YOUR APPOINTMENT you will be charged a fee of $50.00. The missed appointment fee must be paid prior to rescheduling your next appointment.

Returned Checks: There is a $50.00 fee for any checks returned from the bank.

Past Due Accounts: Any accounts over 90 days are automatically referred to a collection agency or reported as a delinquent to the credit bureau. You agree to pay all costs which are incurred as a result of these actions. We understand that temporary financial problems may affect timely payment of your balance, we encourage you to call us so that we can assist you in the management of your account if necessary.

- I understand and agree that I am responsible for payment of all charges on my account regardless of any estimates of fees and/or insurance coverage
- Insured patients, I understand and agree that after my insurance carrier processes my claim(s), there could be a balance still remaining to be paid by me and must be paid immediately upon receipt of statement. I hereby authorize payments directly to Centerville Family Dental, LTD for insurance benefits otherwise payable to me.

Name of person Responsible for Account: _____

Relationship: self ____ parent/legal guardian_____

Signature: _____ Print Name: _____ Date: ___/___/___

Staff Signature: _____ Print Name: _____ Date: ___/___/___

Centerville Family Dental, LTD – Notice of Privacy Practices- HIPAA

Our practice is committed to protecting your **Personal Health Information (PHI)** in accordance with the Health Insurance Portability and Accountability Act (HIPAA). This notice explains how your medical and dental information may be used and disclosed, and how you can access this information.

Uses and Disclosures of your health information (may include but not limited to):

- Sharing information with other healthcare providers involved in your care.
- Sharing information with insurance companies for billing purposes.
- Internally, to all staff members who have any role in your treatment
- To other patients and third parties who may overhear conversations about your treatment, scheduling, etc.
- For quality assessments, audits, and office management.

Under the new privacy rules you have the right to:

- Request restrictions on the use and disclosure of your PHI
- Request confidential communication of your PHI
- Inspect and obtain copies of you PHI through asking us
- Amend or modify your protected PHI

Substance Use Disorder Information:
Certain health information related to substance use disorder treatment is protected by federal confidentiality regulations. This information will only be used or disclosed with your authorization or as permitted by law, and recipients may be prohibited from further re-disclosing it.

Privacy Complaints:
If you believe your privacy rights have been violated, you may file a complaint with our Practice Manager or the U.S Department of Health and Human Services.

Patient Acknowledgement:
I acknowledge that I have received a copy of the dental office's HIPAA Privacy Notice
(Full copy available upon request)

Patient Signature or Legal Guardian: _____
Print Name of Patient: _____
Date: ___/___/___

Centerville Family Dental, LTD attempted to obtain written acknowledgment of our "Notice of Privacy Practices"

☐ Individual refused to sign (specify): _____
☐ Communication barriers prohibited obtaining the acknowledgment
☐ Other: _____