Welcome - Patient registration

Patients Name: _____ Date of Birth: _____
last first initial

If child: Parent's Name:_____

Please circle: Male/Female SS# _____

Address: _____

City: _____ State:_____ Zip: _____

Phone: _____Work: _____

Cell: _____ Other: _____

Email: _____

Person responsible for account: _____

Someone to notify in case of emergency:_____Phone:_____

_____

Whom may we thank for this referral? _____

Dental Insurance:_____ Phone: _____

Primary Name: _____ Member/SS #: _____

Employer Name: _____ Group # _____

Primary Date of birth: _____ Relationship to member: _____

CONSENT:

1. I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.
2. I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment of payment.
3. I consent to the disclosure of my records (or my child's records) to **the following persons** who are involved in my care(or my child's care) or payment for that care.

_____

4. My consent to disclosure of records shall be effective until I revoke it in writing
5. I authorize payment directly to the dentist of insurance benefits otherwise payable to me. I understand that my dental care insuance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid by my dental care payor.
6. I attest to the accuracy of the information on this page.

_____ _____

Patient's signature /if minor - Guardian's Signature Date

Medical History

Patient Name: _____ Date: _____

Primary care physician Name: _____ Phone: _____

Are you under physician's care for any thing specific(please explain): _____

_____

When was your last complete physical exam: _____

Please list any medication you are taking including vitamins or suppliments:_____

_____

Do you have any allergies(medications, latex, metal sensitivities)	**Y / N**
please list if so:	
Are you pregnant or do you suspect you may be?	**Y / N**
Do you use birth control?	**Y / N**
Have you ever been treated for or do you have heart disease?	**Y / N**
Do you have a pacemaker, artificial heart valve implant, or been diagnosed with mitral valve prolapse?	**Y / N**
Have you ever had rheumatic fever?	**Y / N**
Are you aware of any heart murmers?	**Y / N**
Do you have high or low blood pressure?(please circle)	**H/L / N**
Have you ever had a serious illness or major surgery?	**Y / N**
If so please explain:	
Have you ever had radiation treatment,chemo treatment for tumor,growth or condition?	**Y / N**
Have you ever taken Fosamax,Zometa,Aredia, or any other oral intravenous treatment (biophosphonates) for bone tumors, excessive calcium in you blood, or osteoporosis?	**Y / N**
Do you have inflammatory diseases, such as arthritis or rheumatism?	**Y / N**
Do you have any artificial joints/prosthesis?	**Y / N**
Do you have any blood disorders, such as anemia, leukemia, or have you ever bled excessively after being cut or injured?	**Y / N**
Do you have any stomach problems?	**Y / N**
Do you have any kidney or liver problems?(please circle)	**Y / N**
Are you Diabetic?	**Y / N**
Do you have fainting or dizzy spells?	**Y / N**
Do you have asthma?	**Y / N**
Do you have epilepsy or seizure disorders?	**Y / N**
Do you have or have you had venereal or an sexually transmitted disease?	**Y / N**
Do you have AIDS or have you tested positive for HIV?	**Y / N**
Do you have or do you test positive for hepatitis?	**Y / N**
Do you have or have you had T.B.?	**Y / N**
Do you smoke, chew, use snuff or any other forms of tobacco?	**Y / N**
Do you regularly consume more than one or two alcoholic beverages a day?	**Y / N**
Do you habitually use controlled substances?	**Y / N**
Have you had psychiatric treatment?	**Y / N**
Have you taken any prescription drugs fenfluramine, fenfluramine combined with pentermine(fen-phen), dexfenfluramine(redux), or other weight loss products?	**Y / N**
Do you have any disease or condition not listed? If so, explain	**Y / N**
Would you like to speak to the doctor privately about any problem?	**Y / N**

I CERTIFY THAT THE INFORMATION ABOVE IS COMPLETE AND ACCURATE

Patient/Guardian Signature: _____ Date: _____
Dentist Signature: _____ Date: _____

Dental History

Patient Name: _____ Date: _____

What is the main reason for your appointment today:

_____

Please list any significant dental history:

_____

How important is the way your teeth look?	Low	Medium	High	
please list any specific concerns:				
How well can you chew?	Poor	Fair	Well	
please list any specific concerns:				
Have you ever been diagnosed with a problem with either jaw or joint?				**Y / N**
Do you wear a night guard?				**Y / N**
Does your jaw click, pop, or make noise when you open or close?				**Y / N**
Do you have pain or tenderness in your jaw when you open, close or chew?				**Y / N**
Has your jaw ever locked open or closed?				**Y / N**
Do you have frequent head aches? If so how often or when?				**Y / N**
Do you clench or grind your teeth, or been told that you do?				**Y / N**
Do you have history of trauma to your chin or jaw?				**Y / N**
Do you or have you been told that you snore				**Y / N**
Have you been diagnosed with sleep apnea?				**Y / N**
Do you wear a CPAP or dental appliance?				**Y / N**
Please list any any additional concerns/details below:				

Patient/Guardian Signature: _____ Date: _____
Dentist Signature: _____ Date: _____

Corey G. Warrenbrand, DMD

Notice of Privacy Practices for Protected Health Information

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully!

The office is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination, and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Cancelation Policy - We request that you please call at least 48 hours prior to your scheduled appointment so that we may give that appointment time to another patient with dental needs. We reserve the right to charge a cancelation fee or require prepayment before rescheduling for repeat cancelations.

Financial Policy - Dental treatment is an excellent value and investment in an individual's medical and psychological well-being. We accept and file dental insurance on your behalf. Insurance estimates are never a guaranteed amount. We calculate insurance estimates based on the information provided to us by your insurance company. Your portion of the estimate will be due at time of service. Any balance after insurance payment is received will be your responsibility. We accept the following payment options:

- Cash or Personal Check
- Credit Card
- Monthly Payments
- (Available for balance over $500, please inquire with Treatment Coordinator)

_____ Date: _____

Patient Signature