JOY DENTAL

PATIENT REGISTRATION FORM

Date: _____/_____/_____

- ***How did you hear about us? (Circle One)*** *Referral / Website / Advertisement / Other:* _____
- ***Whom may we thank for referring you?*** _____

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

Home Phone: (_____)_____ Cell Phone: (_____)_____ Work Phone: (_____)_____

Date of Birth: _____/_____/_____ Social Security No.: _____

Address: _____ City: _____ State: _____ Zip: _____

Sex (Please circle) : M / F Marital Status: _____ Email: _____

Name of Emergency Contact: _____ **Phone: (_____)** _____ **Relationship to Patient:** _____

RESPONSIBLE PARTY (If Patient Is A Minor):

Name of Responsible Party: _____ Relationship to Patient: _____

Home Phone: (_____)_____ Cell Phone: (_____) _____

Address (if different): _____ City: _____ State: _____ Zip: _____

PRIMARY INSURANCE INFORMATION- *Please Fill Out Completely*

Name of Policy Holder (if different): _____ Relationship to Patient: _____

Date of Birth of Policy Holder: _____/_____/_____ **Social Security No. of Policy Holder:** _____

Home Address of Policy Holder: _____ City: _____ State: _____ Zip: _____

Phone Number of Policy Holder: (_____)_____

Insurance Company: _____ **Subscriber ID #:** _____

Insurance Address: _____ City: _____ State: _____ Zip: _____

Insurance Phone: (_____) _____ Employer Name: _____

SECONDARY INSURANCE INFORMATION- *Please Fill Out Completely*

Name of Policy Holder (if different): _____ Relationship to Patient: _____

Date of Birth of Policy Holder: _____/_____/_____ **Social Security No. of Policy Holder:** _____

Home Address of Policy Holder: _____ City: _____ State: _____ Zip: _____

Phone Number of Policy Holder: (_____)_____

Insurance Company: _____ **Subscriber ID #:** _____

Insurance Address: _____ City: _____ State: _____ Zip: _____

Insurance Phone: (_____) _____ Employer Name: _____

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain _____	☐	☐
3. Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking? _____	☐	☐
4. Have you ever taken Fen-Phen/Redux?	☐	☐
5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?	☐	☐
6. Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours?	☐	☐
7. Do you use tobacco?	☐	☐
8. Do you use controlled substances?	☐	☐
9. Do you have or have you had any of the following?		

	Yes	No
10. Are you wearing contact lenses?	☐	☐
11. Are you allergic to or have you had any reactions to the following?		
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other (please list) _____		
12. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	☐	☐
13. Women Only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever / Allergies	☐	☐
Fainting / Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy / Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Diseases	☐	☐	Hepatitis / Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Mitral Valve Prolapse	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles / Ulcers	☐	☐	Other _____	☐	☐

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐

	Yes	No
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials? If yes, date of placement _____	☐	☐
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____

Signature of patient (or parent/guardian if minor) Date

Doctor's Comments _____

_____

_____ Signature _____ Date _____

INFORMED CONSENT FOR DENTAL TREATMENTS & FINANCIAL RESPONSIBILITIES

Please read, initial where appropriate, and sign below.

1. Preliminary Consent for Treatment

I understand I am having any or all of the following done today: Exam, X-Rays, and Cleaning (Prophylaxis). I hereby authorize the doctor and/or the designated staff to take X-Rays, models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs.

Initials_____

2. Medications, Substances, and Medical Conditions

I understand that antibiotics, analgesics "pain medicines", anesthetics, latex, and other substances can cause allergic reactions, resulting in redness and swelling of tissues, itching, pain, vomiting and/or more severe allergic reactions. I have informed this office of any known allergies and/or medical conditions, including pregnancy or the possibility of pregnancy.

Initials_____

3. Changes to my Treatment Plan

I understand that during treatment it may be necessary to change or add procedures because of conditions found during treatment that were not evident during the initial examination. Some of these changes are, but are not limited to, Root Canal Therapy, which may be necessary following the placement of large fillings, and the placement of a Crown, recommended after Root Canal Therapy. I authorize my dentist to make any changes and/or additions to my treatment plan as necessary.

Initials_____

4. My Financial Responsibilities

I understand that payments are due in full at the time of treatment unless prior arrangements have been approved by Joy Dental and I agree to pay for all services rendered by this office. Should I utilize my dental insurance, I understand that the treatment plan that my dentist recommends is based on what my doctor determines is best for my dental health and not necessarily based on what my insurance will cover. Therefore, I am aware that my insurance may not cover all aspects of my treatment plan and I will be held financially responsible to pay for any treatments not covered by my insurance. I also understand that the treatment plan proposed to me is an estimate of insurance benefits and my actual coverage may differ due to frequency and coverage limitations, incomplete information provided by my insurance company, and/or termination of my insurance. Therefore, I acknowledge that I will be held responsible for any balance remaining due to any of these reasons.

Initials_____

By signing below, I agree to ALL of the above statements and I authorize Joy Dental to submit Insurance Claims and Pre-Authorizations on my behalf if necessary. I also understand that my signature below will constitute as my "Signature on File" which is needed to submit these forms. I am fully aware that dental treatments have potential risks and consequences and that dentistry is not an exact science and that no exact results can be assured or guaranteed.

_____ _____/_____/_____

Name of Patient **Date**

_____ _____

Signature of Patient or Responsible Party **Relationship to Patient (if applicable)**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that, under the Health Insurance portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple health care provides who may be involved in that treatment directly and indirectly
2. Obtain payment from third-party payers.
3. Conduct normal health care operation such as quality assessments and physicians certifications.

I have received, read, and understand the **Notice of Privacy Practices** containing more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you, Joy Dental, restrict how my private information is used or disclosed to carry out my treatment, payment, or healthcare operations. I also understand that you, Joy Dental, are not required to agree to my restriction requests, but if you do agree then you are bound to abide by such restrictions.

_____ _____/_____/_____

Name of Patient **Date**

_____ _____

Signature of Patient or Responsible Party **Relationship to Patient (if applicable)**