PATIENT REGISTRATION AND MEDICAL HISTORY

Date _____ (PLEASE PRINT) Home Phone (____) _____

Patient _____
Last Name First Name Middle Initial Preferred Name

Street Address _____ City _____ State _____ Zip _____

E-mail _____ Cell Phone (____) _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone (____) _____

Spouse/Parent Name _____ Spouse/Parent Birthdate _____

Spouse/Parent Employed by _____ Occupation _____

Business Address _____ Business Phone (____) _____

Who is responsible for this account? _____ Relationship to Patient _____

Social Security # _____ Spouse/Parent's Social Security # _____

Name of Dental Insurance Company _____ Group Number _____

In case of emergency, who should be notified? _____ Phone (____) _____

Whom may we thank for referring you? _____

MEDICAL HISTORY

Physician's Name _____ Date of Last Physical _____

Have you ever had any of the following? (check boxes that apply):

☐ Allergies
☐ Arthritis
☐ Artificial Heart Valves or Joints, Screws, etc
☐ Back Problems
☐ Bleeding Abnormally
☐ Blood Disease
☐ Cancer
☐ Chemical Dependency
☐ Chronic Diarrhea
☐ Circulatory Problems
☐ Congenital Heart Lesions
☐ Diabetes
☐ Epilepsy
☐ Headaches
☐ Heart Murmur
☐ Heart Problems
☐ Hemophilia
☐ Hepatitis, Jaundice or Liver Disease
☐ Hernia Repair
☐ High Blood Pressure
☐ HIV/AIDS
☐ Low Blood Pressure
☐ Mitral Valve Prolapse
☐ Nervous Problems
☐ Pacemaker
☐ Psychiatric Care
☐ Radiation Treatment
☐ Recent Weight Loss
☐ Respiratory Disease
☐ Rheumatic Fever
☐ Sinus Problems
☐ Special Diet
☐ Stroke
☐ Swollen Neck Glands
☐ Ulcer
☐ Venereal Disease

Do you have any drug allergies or have you ever had an adverse reaction to any medication or anesthesia? ☐ Yes ☐ No

If so, what? _____

Have you ever responded adversely to medical or dental treatment? ☐ Yes ☐ No

Are you taking any medication at this time? _____ If so, what? _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine.) ☐ Yes ☐ No

Are you under the care of a physician? ☐ Yes ☐ No For what conditions? _____

If patient is a child, what is his/her weight? _____

(Women) Do you suspect that you are pregnant? ☐ Yes ☐ No Due date _____

Are you nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Is there anything else we should know about your medical history? _____

_____

CERTIFICATION

To the best of my knowledge, the information provided on this form is complete and correct. I understand that it is my responsibility to inform my doctor if my minor child ever has a change in health.

MINOR/CHILD CONSENT

I am the parent, guardian, or personal representative of _____
Please Print Name of Minor/Child

and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

INSURANCE ASSIGNMENT AND RELEASE

I certify that my dependent(s) is covered by insurance with _____
Name of Insurance Company(ies)

and assign directly to Dr. Pamela D. Edwards Family Dentistry all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my minor/child's health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents, guardians or personal representatives are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges for services or items provided to me or the patient. I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all charges.

X Sign here.

Signature of Parent, Guardian or Personal Representative _____ Date _____

Please print name of Parent, Guardian or Personal Representative _____ Relationship to Patient _____

MEDICAL HISTORY UPDATE

Has there been any change in the patient's health since the last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Is the patient taking any new medications? _____ If so, what? _____

Date _____ Patient Signature _____

Date _____ Dentist Signature _____

MEDICAL HISTORY UPDATE

Has there been any change in the patient's health since the last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Is the patient taking any new medications? _____ If so, what? _____

Date _____ Patient Signature _____

Date _____ Dentist Signature _____

- Ask to see or get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or 60 days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax, or email shown at the beginning of this notice.
- Ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you asked us. We will send the corrected information to the persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax, or email shown at the beginning of this notice.
- Get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment, or health care operations; disclosures with your authorization, incidental disclosures, disclosures required by law, and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of this extension in writing. If you want a list, send a written request to the office contact person at the address, email, or fax shown at the beginning of this notice.
- Get additional paper copies of this notice of privacy practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, email, or fax shown at the beginning of this notice.

OUR NOTICE OF PRICVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and/or post it on our website.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to contact us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, email, or fax shown at the beginning of this notice. If you prefer, you can discuss your complaint in person or by phone.

DENTAL URGENT CARE

Office Policy

There is an adage that states, *"A* stitch in time saves nine."

We are aware there are reasons patients cannot keep their appointments, but none that surpass a courtesy phone call. Please call to cancel or change your appointment at least 24 hours in advance so that we can schedule another patient and our time is not lost. Without this notification, there may be a $50 broken appointment charge. Any patient, who due to failed appointments, requests their records for another dentist may be required to pay a $50 duplication fee. Patients with multiple broken appointments will be placed on our failed appointments list and may only be given standby appointments.

Please give us a valid phone number to contact you 24 hours before your appointment. If a valid number isn't provided and you do not contact us the day before your appointment to confirm; your appointment may be given to someone else.

Unpaid Balances: If you fail to pay for services rendered after insurance is filed or upfront for cash paying individuals, your account may be turned over to a collection agency. In the case of default on your account, the responsible party is liable for any and all collection fees and for reasonable attorney fees.

If your balance is paid by check and your check is dishonored or returned for any reason, we will electronically debit your account for the amount of the check plus a processing fee of $25.00

GUARANTEE OF WORK DONE: On fillings, our policy is you have 1 month to change your mind about how you feel on the filling (fit, shade, look, etc.) and a 1 year guarantee on the work done. On crowns, you have 3 months to change your mind about how you feel on the crown (fit, shade, look, etc.) and a 5-year guarantee on the work done, providing you keep a 3-6-month recall.

Signature _____ DATE: _____