PATIENT REGISTRATION

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

Preferred Name: _____

Patient is: □ Responsible Party □ Policy Holder

Responsible Party: (if someone other than the patient)

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

Address: _____ Address 2: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birth date: _____ Social Security #: _____ Drivers Lic#: _____

○ Responsible Party is Policy Holder for Patient ○ Primary Policy Holder ○ Secondary Policy Holder

Patient Information:

Address: _____ Address 2: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Sex: ○ Female ○ Male Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth date: _____ Social Security #: _____ Drivers Lic#: _____

E-mail: _____ □ I would like to receive email correspondences

Patient Information (section 2):

Employment Status: ○ Full Time ○ Part Time ○ Self Employed ○ Retired ○ Unemployed

Student Status: ○Full Time ○ Part Time

Preferred Dentist: _____ Preferred Hygienist: _____ Preferred Pharmacy: _____

Referred By: _____ Emergency Contact: _____ Emergency Contact #: _____

Medicaid ID: _____

Primary Insurance Information:

Name of Insured: _____ Relationship to Insured: ○Self ○Spouse ○Child ○ Other

Employer ID: _____ Carrier ID: _____

Insured Social Security #: _____ Insured Birth date: _____

Employer: _____

Address: _____

Address 2: _____

City, State, Zip: _____

Insurance Company:
Address:
Address 2:
City, State, Zip:

MEDICAL HISTORY

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 _____

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

_____ _____

Please ***print*** name of Patient Please ***sign*** for Patient / Guardian of Patient

_____ _____

Legal Representative / Guardian Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents: _____

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA: ☐ First Name Only ☐ Proper Surname ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: (This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

☐ Phone Message
☐ Text Message
☐ **Any of the Above**
☐ **None of the above** (opt out) ☐ Email

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment ____
I could not communicate with the patient ____
The patient refused to sign ____
The patient was unable to sign because ____
Other (please describe) ____

_____
Signature of Privacy Officer

IN AGREEMENT WITH OUR FINANCIAL ARRANGEMENT, THE FOLLOWING TERMS AND CONDITIONS WILL APPLY IN ALL CASES WHERE SERVICES OFFERED AT OUR OFFICE ARE ACCEPTED AND SUBSEQUENT TREATMENT IS PROVIDED.

The credit grantor, LHN PLLC, may add an additional 1.5% fee to any balance owed.

We do not guarantee insurance coverage. Insurance estimates are not a guarantee of dental benefits offered by your dental plan. If your insurance carrier denies any treatment or financial coverage for any reason, including any services that are denied as dentally unnecessary, by acknowledging consent with your signature below, you agree to the treatment presented and are held financially liable for any and all unpaid balances.

In the event of default I/We _____, will be responsible for collection charges, court costs and/or attorney fees.

_____ _____

Patient Name: Print Witness/Office Representative

_____ _____

Patient/Guardian: Signature Date