



Patient Registration

First name: _____ Last name: _____ Patient is: Responsible party Child
Address: _____ City: _____ State: _____ Zip: _____
Home phone _____ Cell phone: _____ Work phone: _____
Sex: Male Female Birth date: _____ Material status: Single Married Divorced
Social security number: _____ Email address: _____
How did you hear about us? _____
Employer name: _____ Employer phone: _____
Emergency contact: _____ Relation: _____ Phone number: _____

Responsible Party (Guardian of patient, if patient is under 18 years old) Currently a patient in our office Yes No

First name: _____ Last name: _____ Relation to patient: _____
Address: _____ City: _____ State: _____ Zip: _____
Home phone _____ Cell phone: _____ Work phone: _____
Sex: Male Female Birth date: _____ Material status: Single Married Divorced
Social security number: _____ Email address: _____
Employer name: _____ Employer phone: _____

Insurance Information

Primary insurance: _____
Insurance address: _____
Insurance Phone number: _____
Name of Subscriber: _____
DOB: _____ Social or ID #: _____
Relationship to patient: _____

Secondary insurance: _____
Insurance address: _____
Insurance Phone number: _____
Name of Subscriber: _____
DOB: _____ Social or ID #: _____
Relationship to patient: _____

Dental History

Reason for today's visit _____ Date of last dental care _____

Former dentist _____ Date of last dental x-rays _____

Check the boxes if you have or have had problems with any of the following:

- | | | |
|--|--|--|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Sensitivity to hot |
| <input type="checkbox"/> Loose fillings | <input type="checkbox"/> Loose teeth | <input type="checkbox"/> Sensitivity to cold |
| <input type="checkbox"/> Clicking/ popping jaw | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Food collecting between the teeth | <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Sensitivity to biting |

How often do you floss _____ How often do you brush _____

Medical History

Physician's name _____ Phone number _____ Date of last visit _____

Are you currently, or recently, been taking Bisphosphonate medications? Yes No

Have you ever had any serious illnesses or operations? Yes No If yes, describe _____

Do you require antibiotic pre-medication for heart condition, artificial valve, or artificial joint? Yes No

Are you pregnant? Yes No Due: _____ Nursing? Yes No Taking birth control pills? Yes No

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Congenital Heart Lesions | <input type="checkbox"/> Hernia Repair | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Artificial Joints, Pins, ect | <input type="checkbox"/> Cough up Blood | <input type="checkbox"/> Jaw Pain/TMJ | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Bleeding Abnormally | <input type="checkbox"/> Fainting | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Hepatitis Type: _____ | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Other _____ |

List medications you are currently taking:

Are you currently on a pain contract with your physician? Yes No

Have you ever undergone psychiatric care? Yes No

Allergies:

- | | | | |
|--|---------------------------------------|---|--------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Latex | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Barbiturates (Sleeping pills) | <input type="checkbox"/> Iodine | <input type="checkbox"/> Local Anesthetic | <input type="checkbox"/> None |
| <input type="checkbox"/> Clindamycin | <input type="checkbox"/> Codeine | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Other _____ |

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Patient name: _____

Date: _____

Signature (parent or guardian if minor): _____

Relationship to patient: _____

Consent to Proceed

I authorize Dr. Kyle K. Harmon and/or such associates or assistants as s/he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic, or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval. Occasionally drops of local anesthetic may contact the eyes and facial tissues and cause temporary irritation.

I understand that as a part of dental treatment, including preventative procedures such as cleanings and basic dentistry including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. Dental materials and medications may trigger allergic or sensitivity reactions.

After lengthy appointments, jaw muscles may also be sore or tender. Holding one's mouth open can, in a predisposed patient, precipitate a TMJ disorder. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is possible for the tongue, cheek, or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases, sutures or additional treatment may be required.

I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, drill components, ect. may be aspirated (inhaled) into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensure safe removal.

I understand the need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past, such as Phen-Fen. I understand that taking the class of drugs prescribed for prevention of osteoporosis, such as Fosamax, Boniva, or Actonel, may result in complications of non-healing of the jaw bones following oral surgery or tooth extractions.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventative and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me in necessary and I have been given the opportunity to ask questions.

Patient name: _____

Signature: _____

Date: _____

Witness: _____

Date: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability and Accountability Act of 1996 ("HIPPA") and all future amendments made, I have certain rights to privacy information can and will be used to:

Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

Obtain payment from third-party payers.

Conduct normal healthcare operation such as quality assessments and physician certifications.

I have received, read, and understand your Notice of Privacy Practices containing a 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 any time 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 restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are required to agree to my requested restriction, but if you do agree then you are bound to abide by such restrictions.

Patient name: _____

Signature: _____

Date: _____

Witness: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date _____ Initials _____ Reason _____

Dental Payment agreement

We would like to welcome you to our dental office and inform you of our policy regarding fees.

For our patients with dental coverage: I understand that Central Davis Dental cannot render services on the assumption that any of the charges will be paid by an insurance company. I understand that I am financially responsible for all charges whether paid by my insurance or not. I understand that my treatment plan is **only an estimate** of what my insurance may pay. **It is not a guarantee of payment from my insurance company.** Fees vary with type of procedure and complexity of treatment. Your insurance sets specific fees for every procedure that Central Davis Dental is contracted to follow. I understand that estimated payment for services is due at the time of treatment. If the insurance company refuses payment, nor does not pay in full or does not pay the full estimated amount, I understand I am responsible for the remaining outstanding balance.

I authorize my insurance company to pay Central Davis Dental all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submission. I authorize the dentist to release all information necessary to secure payment of benefits

For patients without dental coverage: Payment for services is due at the time of treatment.

Returned Checks: I understand that a \$40.00 charge will be applied to all returned checks.

Unpaid balances: I understand that if I do not pay my bill collection action may be taken and I will be responsible for paying any collection and attorney fees. Should collection become necessary, the responsible party agrees to pay an additional 33.3% collection fee, and all legal fees of collection, with or without suit, including attorney fees and court cost.

Missed appointments: I understand that there will be a \$25.00 charge for any appointments rescheduled less than 24 hours in advance or any missed appointment.

Patient name: _____

Signature: _____

Date: _____

Witness: _____

Date: _____

Dental care financing: Financing is available upon request and approval at the front desk with an agreed percentage of a finance charge. A portion of the balance is usually required up front to be approved. You can also make in advance lay-away payments before your procedure is started. We partner with Care Credit and Citi Bank for financing options at 0% interest (upon approval). You can apply here with us or by going to www.carecredit.com. If approved, print off approval with your account number and bring to your appointment.