

# DENTAL REGISTRATION AND HISTORY

## 1

### PATIENT INFORMATION

Date \_\_\_\_\_

SS/HIC/Patient ID # \_\_\_\_\_

Patient Name \_\_\_\_\_  
Last Name \_\_\_\_\_  
First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Address \_\_\_\_\_

E-mail \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

Sex ☐ M ☐ F Age \_\_\_\_\_

Birthdate \_\_\_\_\_

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for \_\_\_\_\_ years

Patient Employer/School \_\_\_\_\_

Occupation \_\_\_\_\_

Employer/School Address \_\_\_\_\_

Employer/School Phone (\_\_\_\_) \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Birthdate \_\_\_\_\_

SS# \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## 2

### DENTAL INSURANCE

Who is responsible for this account? \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

**ASSIGNMENT AND RELEASE**

I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_ and assign directly to \_\_\_\_\_  
Name of Insurance Company(ies)

Dr. \_\_\_\_\_ 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 dentist may use my 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 my current treatment plan is completed or one year from the date signed below.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Please print name of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

## 3

### PHONE NUMBERS

Phone (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ Ext \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_

Spouse's Work (\_\_\_\_) \_\_\_\_\_ Best time and place to reach you \_\_\_\_\_

**IN CASE OF EMERGENCY, CONTACT** (Specify someone who does not live in your household.)

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

## 4

### DENTAL HISTORY

Reason for today's visit \_\_\_\_\_

Former Dentist \_\_\_\_\_

City/State \_\_\_\_\_

Date of last dental visit \_\_\_\_\_

Date of last dental X-rays \_\_\_\_\_

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	Burning sensation on tongue	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth breathing	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding gums	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chew on one side of mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth pain, brushing	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blisters on lips or mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cigarette, pipe, or cigar smoking	<input type="checkbox"/> Yes <input type="checkbox"/> No	Orthodontic treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Clicking or popping jaw	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain around ear	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Dry mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Periodontal treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Fingernail biting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to cold	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Food collection between the teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to heat	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Foreign objects	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to sweets	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Grinding teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity when biting	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Gums swollen or tender	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sores or growths in your mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Jaw pain or tiredness	<input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you floss? _____	
		Lip or cheek biting	<input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you brush? _____	
		Loose teeth or broken fillings	<input type="checkbox"/> Yes <input type="checkbox"/> No		



## 5

## HEALTH HISTORY

Physician's Name \_\_\_\_\_ Date of last visit \_\_\_\_\_

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. ☐ Yes ☐ NoHave 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

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting or dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis, Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis Type _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Special Diet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding abnormally, with extractions or surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Feet or Ankles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Neck Glands	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Lesions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumor or growth on head or neck	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cortisone Treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough, persistent or bloody	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervous Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weight Loss, unexplained	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you wear contact lenses?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No		

**Women:**Are you pregnant? ☐ Yes ☐ No

Due date \_\_\_\_\_

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

## MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

\_\_\_\_\_  
\_\_\_\_\_

Pharmacy Name \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_

## ALLERGIES

☐ Aspirin☐ Local Anesthetic☐ Barbiturates (Sleeping pills)☐ Penicillin☐ Codeine☐ Sulfa☐ Iodine☐ Other \_\_\_\_\_☐ Latex

## 6

## UPDATES (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? \_\_\_\_\_

Are you taking any new medications? \_\_\_\_\_ If so, what? \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? \_\_\_\_\_

Are you taking any new medications? \_\_\_\_\_ If so, what? \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_

# Rajinder Singh Bhullar, DDS, PA

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10905 Fort Washington Road, Suite 207, Fort Washington, MD 20744

## **Rajinder Singh Bhullar, DDS, PA Financial Policy**

- ❖ Payment for services are due in full, at the time services are started. Meaning services that require multiple visits are to be paid in FULL on the first visit.
  - Initial \_\_\_\_\_ (staff \_\_\_\_\_)
  
- ❖ We file your dental claim to your insurance company at no cost and as a courtesy to you. We will provide you with the closest estimate for your services. The estimate is not a guarantee of payment. Insurance companies may pay more (patient would be due a refund) and may pay less (patient will receive an invoice/statement) than estimated. If the insurance company does not pay in full the remaining unpaid balance is and will be patient responsibility.
  - Initial \_\_\_\_\_ (staff \_\_\_\_\_)
  
- ❖ Dr. Bhullar strives to be on time and respect our patients time. We require the same in return, and reserve the right to place scheduling stipulations on any patient account that we deem necessary. Example stipulations; a) require prepayment to schedule, b) only allow for 2 patients in the same family to schedule on the same day, ect.
  - Initial \_\_\_\_\_ (staff \_\_\_\_\_)
  
- ❖ There is a 24 hour notice required to change your appointment date/time. Any Broken Appointments or No Shows will result in a \$40.00 (appointments 30 minutes or less), \$60.00 (appointments 60 minutes to 90 minutes) and \$80.00 (appointments 91 minutes or more) fee being charged to your account. The fee assessed MUST be paid BEFORE making any further appointments and any other appointments you may already have may be canceled (office discretion will be used). Saturday appointments require a 48 hour notice to change and the patients' ability to schedule on a Saturday will be revoked if the appointment is broken along with the above fee's.
  - Initial \_\_\_\_\_ (staff \_\_\_\_\_)



**Rajinder Singh Bhullar, DDS, PA Financial Policy continued:**

- ❖ Returned checks are subject to a fee of \$50.00 per returned item.
  - Initial \_\_\_\_\_ (staff \_\_\_\_\_)
  
- ❖ Balances not paid in a timely manner will be placed for outside collection. Placement of accounts with a collection agency may affect your credit and will result in additional fees charged to your account which may include but are not limited to; attorney fees, court costs, interest with a rate of 18% per annum, collection agency fees of 33.33% of your account balance due, ect.
  - Initial \_\_\_\_\_ (staff \_\_\_\_\_)

I \_\_\_\_\_, have read and fully understand RSB, DDS, PA Financial Policy and Procedures. I have been given the opportunity to get clarification on anything I did not understand and I agree to all of the above terms and conditions.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Patient DOB

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date

# Rajinder Singh Bhullar, DDS, PA

10905 Fort Washington Road, Suite 207, Fort Washington, MD 20744

## **HIPAA Notice of Privacy Practices**

**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.**

This notice of privacy practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you including demographic information that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

### **Uses and disclosures of protected health information**

Your protected health information may be used and disclosed by your physician, our office and others outside of our office that are involved in your care and treatment for the purpose of providing healthcare services to you, to pay your healthcare bills, to support the operation of the physicians practice, and any other use required by law.

**Treatment:** we will use and disclose your protected health information to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third-party. For example, we would disclose your protected health information, as necessary to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare operations:** We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose protected health information to medical school students that see patients at our office. In addition, we may use a sign in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclosure of protected health information in the following situations without your authorization. These situations include, as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirement, legal proceedings, law-enforcement, coroners, Funeral directors, and organ donation, research, criminal activity, military activity and national security, Worker's Compensation, inmates, required uses and disclosures, under the law, we must make disclosures to you and when required by the secretary of the department of health and human services to investigate or determine are compliant with the requirements of section 164.500. Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke this authorization at any time, in writing, except to the extent that your physician or physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.



**Your Rights:** following is a statement of your rights with respect to your protected health information, you have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect the following records, psychotherapy notes, information compiled in reasonable anticipation of, or use in a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

#### **HIPAA Privacy Cont.**

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this notice of privacy practices. Your request must state the specific restriction requested into which you want the restriction to apply; your physician is not required to agree to a restriction that you may request. If a physician believes it is in your best interest to permit use and disclosure of your personal protected health information, your protected health information will not be restricted. You didn't have the right to use another healthcare professional. Do you have the right to receive confidential communications from us by alternative means or at an alternate location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept his notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of such rebuttal. You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

**Complaints:** you may complain to us or the secretary of health and human services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint. This notice is published and becomes effective on or before April 14, 2003..

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form please ask to speak with our HIPAA compliance officer in person or by phone at our main phone number.

**Signature below is only acknowledgment that you have received this Notice of Privacy Practices.**

**Print Name:** \_\_\_\_\_ **Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

I (patient name) \_\_\_\_\_ authorize (name of authorized person) \_\_\_\_\_ to obtain my Dental Records on my behalf. I understand that if I decide to revoke this authorization that it must be done in writing and submitted to RSB, DDS, PA.

**Relationship to authorized personnel is** \_\_\_\_\_.

**Date:** \_\_\_\_\_ **Patient Signature:** \_\_\_\_\_