PATIENT REGISTRATION AND HISTORY

Please take a few minutes to fill out this form as completely as possible. If you have any questions, we will be glad to help you.

1 PERSONAL

NAME Dr Mr Mrs Ms Miss

_____
Last First

_____
Middle Name/Initial (Preferred)

BIRTHDATE _____ SS# _____

GENDER: M F MARITAL STATUS: _____

HOME PHONE _____

WORK PHONE _____

CELL PHONE _____

EMAIL _____

PREFERRED CONTACT METHOD

Home Work Cell Email

STUDENT STATUS *(IF DEPENDENT OVER 19 - FOR INSURANCE)*

Non student Full-time Part-time

HOW DID YOU HEAR ABOUT US?

_____

(If someone referred you here, please write down their name so we can thank them.)

2 HOME ADDRESS AND EMPLOYMENT INFORMATION

ADDRESS _____

CITY _____ STATE _____

ZIP CODE _____

OCCUPATION _____

EMPLOYER/SCHOOL _____

PARENT/GUARDIAN INFORMATION *(for minors under 18 years old)*

NAME _____

RELATIONSHIP TO PATIENT _____

PHONE/ADDRESS *(if different from minor's)*

_____

_____

_____

3 INSURANCE

NOT COVERED BY DENTAL INSURANCE ☐

PRIMARY CARRIER

SUBSCRIBER NAME _____

RELATIONSHIP TO PATIENT _____

INSURANCE CARRIER NAME _____

GROUP NUMBER _____

SUBSCRIBER ID # _____

SUBSCRIBER BIRTHDATE _____

SUBSCRIBER ADDRESS

_____

CITY _____ STATE _____

ZIP CODE _____

SECONDARY CARRIER

SUBSCRIBER NAME _____

RELATIONSHIP TO PATIENT _____

INSURANCE CARRIER NAME _____

GROUP NUMBER _____

SUBSCRIBER ID # _____

SUBSCRIBER BIRTHDATE _____

SUBSCRIBER ADDRESS

_____

CITY _____ STATE _____

ZIP CODE _____

4 MEDICAL HISTORY

NAME OF PRIMARY CARE PHYSICIAN _____

CITY/STATE _____

HAVE YOU BEEN HOSPITALIZED IN THE LAST 2 YEARS?

YES NO

REASON? _____

PLEASE LIST ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING:

_____

_____

_____

_____

_____

_____

PLEASE MARK ANY CONDITIONS THAT YOU HAVE OR HAVE A HISTORY OF:

- ☐ Cancer or tumor
- ☐ Radiation/chemotherapy
- ☐ Alcoholism
- ☐ Blood transfusion
- ☐ Diabetes *(Most recent HbA1C?_____)*
- ☐ Epilepsy, seizures, or fainting spells
- ☐ Emotional condition/psychiatric treatment
- ☐ Arthritis
- ☐ Hay fever
- ☐ Rheumatic fever
- ☐ Anemia or blood disorder
- ☐ Abnormal bleeding after extractions, surgery, or trauma
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Joint replacement
- ☐ Ulcers
- ☐ Herpes or cold sores
- ☐ Stroke
- ☐ Heart attack/cardiac condition
- ☐ High blood pressure
- ☐ Pacemaker
- ☐ Migraine headaches or frequent headaches
- ☐ Asthma
- ☐ Tuberculosis
- ☐ Thyroid condition
- ☐ AIDS or HIV positive
- ☐ Hepatitis
  (Please circle) A B C

DO YOU HAVE TO PREMEDICATE PRIOR TO DENTAL VISITS?

Yes No

DO YOU SMOKE OR USE CHEWING TOBACCO?

Yes No

WOMEN:

- ☐ ARE OR MAY BE PREGNANT *(Due date?_____)*
- ☐ TAKING HORMONES OR CONTRACEPTIVES
- ☐ CURRENTLY BREASTFEEDING

ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING:

- ☐ Latex materials
- ☐ Penicillin
- ☐ Sulfa drugs
- ☐ Local anesthetics (“Novocain”)
- ☐ Codeine
- ☐ Barbiturates, sedatives, or sleeping pills
- ☐ Other: _____

DO YOU HAVE ANY DISEASE, CONDITION, OR PROBLEM NOT LISTED ABOVE:

_____

_____

_____

5 DENTAL HISTORY

REASON FOR TODAY’S VISIT? _____

ARE YOU CURRENTLY EXPERIENCING DENTAL PAIN?

Yes No

PREVIOUS DENTIST _____

CITY/STATE _____

HAVE YOU HAD REGULAR DENTAL VISITS IN THE LAST 2 YEARS?
(every six months)

Yes No

ARE YOU CURRENTLY SATISFIED WITH THE APPEARANCE OF YOUR SMILE?

Yes No

IF NOT, WHAT WOULD YOU CHANGE? _____

_____

PLEASE TELL US IF THERE IS ANYTHING ABOUT YOUR DENTAL EXPERIENCE THAT WE SHOULD BE AWARE OF INCLUDING SPECIFIC SMILE CONCERNS, FEAR/ANXIETY, BUDGET RESTRAINTS, OR LIMITATIONS ON TIME/AVAILABILITY?

_____

_____

_____

IN CONJUNCTION WITH RECOMMENDATIONS FROM THE AMERICAN DENTAL ASSOCIATION, WE PROMOTE THE APPLICATION OF FLUORIDE VARNISH FOR ALL OF OUR PATIENTS AT EVERY REGULAR CLEANING APPOINTMENT. **THIS TREATMENT IS GENERALLY NOT COVERED BY INSURANCE PROVIDERS AND WILL INCUR A FEE OF $50.00.** PLEASE INDICATE WHETHER YOU WOULD LIKE TO ACCEPT OR DECLINE THIS TREATMENT *(Note: This will become your default preference.)*

Accept Decline

6 COMMUNICATION PREFERENCES

Please list an individual that we may contact in the event of an emergency.
Also, fill in all names of those with whom we can discuss your treatment, payment, or healthcare operations.

Emergency Contact Person	Relationship to Patient	Phone Number
Other Authorized Person	Relationship to Patient	Phone Number
Other Authorized Person	Relationship to Patient	Phone Number
Other Authorized Person	Relationship to Patient	Phone Number

Please mark any forms of communication that we may use to discuss your treatment, payment, or healthcare operations.

- ☐ Home Telephone
- ☐ Home Telephone Voicemail
- ☐ Work Telephone
- ☐ Work Telephone Voicemail
- ☐ Wireless Telephone
- ☐ Wireless Telephone Voicemail
- ☐ Text Message
- ☐ Email
- ☐ Postal Mail

PLEASE READ THE FOLLOWING CAREFULLY:

The information contained on this form is correct to the best of my knowledge.
I agree to notify Beth Brody, D.D.S. of any changes at each of my appointments.

PATIENT'S SIGNATURE: _____ DATE: _____

(If the patient is a minor, parent/guardian must sign.)

PRIVACY NOTICE AND FINANCIAL POLICY

CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

This acknowledgment of notice and consent authorizes Beth Brody, D.D.S. to use and disclose health information about you and your treatment, payment, and healthcare operations. This practice has a "Notice of Privacy Practices," which describes how we may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning your protected health information.

(PLEASE ASK AT THE FRONT DESK IF YOU DESIRE TO READ OR OBTAIN THE FULL PRIVACY NOTICE.)

I am aware of and/or received a copy of this practice's "Notice of Privacy Practices" and authorize them to use and disclose health information for treatment, payment, and healthcare operations purposes consistent with its "Notice of Privacy Practices."

PATIENT'S SIGNATURE: _____ DATE: _____

(If the patient is a minor, parent/guardian must sign.)

WRITTEN FINANCIAL POLICY

PAYMENT OPTIONS:

You may choose from the following:

- Cash, Visa®, MasterCard®, American Express®, or Discover Card®

- **Beth Brody, D.D.S. requires payment at the time of service.** If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.
- For patients with dental insurance, we are happy to work with your carrier to maximize your benefits and directly bill them for reimbursement for your treatment. Please note, you are responsible for knowing your own benefits and coverage. Insurance reimbursement is never guaranteed, and you are ultimately responsible for the payment of any services received at Beth Brody, D.D.S.
- A fee of $50.00 is charged for patients who miss or cancel more than 1 time in a calendar year without 24-hour notice.
- Beth Brody, D.D.S. charges $35.00 for returned checks.
- I agree to pay finance charges of 1.5% per month (18% APR) on any balance 120 days past due.
- If sent to collections, I agree to pay all related fees and court costs.

PATIENT'S SIGNATURE: _____ DATE: _____

(If the patient is a minor, parent/guardian must sign.)