Patient Registration

Today's Date _____

Last Name _____ First Name _____ MI ____ Date of Birth _____ Age ____

Sex M or F Soc. Sec. # _____ Please Circle One: Single Married Separated Widow

Mailing Address _____ City _____ State ____ Zip Code _____

Email _____ Home Phone (____)_____ Cell Phone (____)_____

Driver's License # _____ Employer _____

Work Phone (____)_____ Occupation _____

Are you a full time student? Yes or No If patient is a minor: Mother's DOB _____ Father's DOB _____

Name of Parent _____ Parent Soc. Sec. # _____

Parent Employer _____ Parent Phone (____)_____

Person Responsible for Account _____ Relationship _____

Emergency Contact _____ Relationship _____ Phone # (____)_____

If you are filling this form out on behalf of another person, what is your relationship to that person?

Name _____ Relationship _____

Reason for today's visit? _____

How did you hear about us?

☐ In-home Mailer ☐ Social Media ☐ Insurance ☐ Practice Website ☐ Internet ☐ Family/Friend/Coworker

☐ Other_____ *Who can we thank for your visit?* _____

Dental Insurance Information (Primary Carrier)

Insured's Name _____

Insured's Employer _____

Insured's DOB _____

Insurance ID # _____ Group # _____

Insurance Co _____

Insurance Co Address _____

Insurance Phone # _____

Dental Insurance Information (Secondary Coverage)

Insured's Name _____

Insured's Employer _____

Insured's DOB _____

Insurance ID # _____ Group # _____

Insurance Co _____

Insurance Co Address _____

Insurance Phone # _____

Dental History

On a scale of 1-10, with 10 being the highest rating:

How important is your dental health to you? 1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health? 1 2 3 4 5 6 7 8 9 10

Where do you want your dental health to be? 1 2 3 4 5 6 7 8 9 10

What would you like to change about your smile?

☐ Color ☐ Bite ☐ Chipped Teeth ☐ Spaces ☐ Crowding ☐ Smile Makeover ☐ Missing Teeth ☐ Whiter Teeth

Please share the following dates:

Your last cleaning ____/____ Your last oral cancer screening ____/____ Your last complete X-rays ____/____

What is the most important thing to you about your future smile and dental health? _____

What is the most important thing to you about your dental visit today? _____

Why did you leave your previous dentist? _____

Name of your previous dentist _____

HEALTH HISTORY FOR DENTAL SERVICES

Patient's Name: _____
(First) (Middle) (Last) (Date of Birth) (Telephone #)

Home address: _____
(Street) (City) (Zip Code) (Emergency Contact Name/Phone #)

1. What kind of dental problem do you have?
_____
_____

2. Has there been any change in your health within the past year? ----------Yes __ No__

3. Are you under the care of a physician ---------- Yes __ No__

4. The name and phone number of my physician is:
_____

5. Have you had any serious illness, accident or operation?
----------Yes __ No__
If so, what was the illness, accident or operation:
_____
_____

6. **Are you required to pre-medicate before any dental treatment? ---------- Yes _____No_____**
If Yes, for what reason: _____

7. Do you have, or have you had the following diseases or problems:
a) Rheumatic Fever or Rheumatic Heart Disease ---- Yes __No __
b) Congenital Heart Lesions ----------Yes __No __
c) Cardiovascular Disease
1) **Artificial Heart Valve----------Yes __ No__**
2**) Heart Attack ----------Yes __ No __**
3) Heart Trouble ----------Yes __ No __
4) Coronary Insufficiency---------- Yes __ No __
5) Coronary Occlusion----------Yes __ No __
6) High Blood Pressure ----------Yes __ No __
7) Arteriosclerosis----------Yes __ No __
8) **Stroke** ----------Yes __ No __
9) Heart Murmur----------Yes __ No __
10) Mitral Valve Prolapse----------Yes __ No __
11) **Endocarditis----------Yes __ No __**
d) Asthma or Hay Fever----------Yes __ No __
e) Fainting Spells or Seizures----------Yes __ No __
f) Diabetes Type 1____Type2____----------Yes __ No __
g) Hepatitis A____B____C_____ ---------- Yes __ No __
h) Liver Disease ---------- -------- Yes __ No __
i) Tuberculosis---------- Yes __ No __
j) Venereal Disease---------- Yes __ No __
k) Human Immune Deficiency Virus (HIV/AIDS) -- Yes __ No __
l) **Joint Replacement ----------Yes__ No___**
Which type? _____Date: _____
m) Other_____
_____

8. Have you ever had abnormal bleeding associated with previous extractions, surgery, or trauma? ------ Yes __No__
a) Have you ever required a blood transfusion? Yes __No__
b) Do you have a **blood clotting disorder ------Yes __No__**
If so, explain: _____

9. Have you had radiation treatment for a tumor, or other condition of your mouth or lips? ----------Yes __No__

10. Do you take any **blood thinner**s? **----------Yes__No___**
Do you take any **bisphosphonates? ----------Yes__No___**

Please list ALL medications you are currently taking:
NONE ☐
_____
_____
_____
_____

11. **Are you allergic to, or have you reacted adversely to**:
a) Local anesthetics ---------- Yes ___ No___
b) Penicillin or Amoxicillin ----------Yes ___ No___
c) Sulfa ----------Yes ___ No ___
d) Barbiturates, sedatives or sleeping pills -Yes ___ No ___
e) Aspirin ---------- Yes ___ No ___
f) Iodine ----------Yes ___ No ___
g) Codeine ---------- Yes ___ No ___
h) Latex ----------Yes ___ No ___
i) Other _____

12. Do you have any disease, condition or problem not listed above that you should let us know about? --Yes ___ No __
If so, please explain: _____
_____

13. List any history of tobacco, alcohol or drug use:
_____
_____

WOMEN

14. **Are you pregnant? ----------Yes __ No __**
How many weeks? _____

15. Any prenatal or birth complications? --------Yes __ No __
If yes, please explain: _____

To the best of my knowledge, the forgoing medical history questions have been accurately answered.

Name_____ Relationship to patient _____

***Signature**_____ **Date** _____

Kodak Dental Care

Your Privacy Is Important to Us

Acknowledgement of Notice of Privacy Policies

If requested, I may receive a copy of the Notice of Privacy Practices of Kodak Dental Care, PLLC. I hereby authorize, as indicated by my signature below, Kodak Dental Care to use and to disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form.

_____ _____

Patient's Name Signature (Guardian if patient is a minor)

_____

Date

Please check your preferred means of communication:

☐ You may contact me at my home telephone number _____

☐ You may contact me on my mobile telephone number _____

☐ You may contact me on my work telephone number _____

☐ You may send me an email at: _____

☐ Other _____

Please list authorized persons with whom we may discuss your Protected Health Information (PHI) in addition to custodial parents and legal guardians:

1. _____Date Added / Removed:_____

2. _____Date Added / Removed: _____

3. _____Date Added / Removed: _____

4._____Date Added / Removed: _____

5._____Date Added / Removed: _____

For Office Use Only:

We attempted to obtain written acknowledgement of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining the acknowledgement

☐ Other (Please Specify) _____

Staff Person Initials _____

PATIENT CONSENT

Clinical

I authorize the dentists of Kodak Dental Care to perform all recommended treatment.

I authorize the Practice to take radiographs, study models, photos, and other diagnostic aids or materials (collectively, "Diagnostic Material") as needed to make a thorough diagnosis. I authorize that such Diagnostic Material may be released to third-party payors and/or other health professionals.

I authorize the use of anesthetics, sedatives, and other medication, as needed, and am fully aware that using anesthetic agents involves certain risks, including but not limited to redness and swelling of tissues, pain, itching, vomiting, dizziness, miscarriage, cardiac arrest, drowsiness, and/or lack of coordination.

My initials by each statement indicate my understanding of our broken appointment policy:

Because reserved appointments require operatory and staff assignment, equipment and instrument setup along with administrative and/or insurance pre-planning, ***please pay close attention to the following requirements:***

☐ • ***We do require a 24 hour business day notice when an appointment has to be cancelled or rescheduled.***

☐ • ***We will ask you to confirm your appointment. Please do so when prompted through the messaging system or you may phone the office.***

☐ • ***We do reserve the right to charge for a broken appointment. After two missed appointments per family, the family is subject to same day only appointments or dismissal from the practice.***

Insurance

I authorize the Practice to release to staff, hospitals, health care service plans, insurance companies, self-insurers or their representatives, any and all information, records, and other Diagnostic Material about my medical history, services rendered, or recommended treatment.

I authorize the Practice to submit claims for payment for services rendered or pre-authorizations necessary to my insurance company, on my behalf and in my name listed as "signature on file" and assign to the Practice the insurance benefits providing assignment is accepted. I am responsible for payment regardless of coverage provided.

Financial

I am responsible for payment for all services rendered on my behalf. I understand that payment is due when services are rendered. Should my account become delinquent, I will be responsible for all additional collection costs, including reasonable attorney fees.

I have read this Patient Consent and agree to all terms and conditions herein.

Patient's or Guardian's (if minor) Signature: _____ Date: _____