Patient Registration

Patient Information

Last Name _____First_____MI_____ Date_____

Address _____

City _____ State _____ Zip Code _____

Mobile # (_____)_____Home Phone # (_____)_____

E-Mail Address _____ Did you visit our website (www.implantdental.com)? ____

Date of Birth _____/_____/_____Social Security # _____-_____-_____ Sex M F Single _____Married _____

Place of Employment _____ Work Phone # (_____)_____Ext#_____

Who referred you to our office? Dr. _____ Friend/Family _____Other _____

Spouses/Guardian Information

Last Name _____First_____MI____ Date of Birth _____/_____/_____

Address _____

City _____ State _____ Zip Code _____

Mobile # (_____)_____Home Phone # (_____)_____

E-Mail Address _____ Social Security #---------- _____

Place of Employment _____ Work Phone # (_____)_____Ext#_____

If you are completing this form for another person, what is your relationship? _____

Dental Insurance Information

Primary Dental Insurance

Insured's Name _____

Insured's Date of Birth _____

Dental Insurance Company _____

Insurance Co Address _____

_____

Insurance Co Phone # _____

Insured's I.D. # _____

Group # _____

***Implant Dental does not participate in any dental insurance plans**. If you have dental insurance, we will file the claim electronically for you. Full payment is required at the time of service and any insurance reimbursement will be sent to you directly by your insurance.*

Signature of Patient or Guardian_____

Secondary Dental Insurance

Insured's Name _____

Insured's Date of Birth _____

Dental Insurance Company _____

Insurance Co Address _____

_____

Insurance Co Phone # _____

Insured's I.D. # _____

Group # _____

Dental History

1. What is your chief complaint (reason for treatment)? _____

2. Date of your last dental exam _____ Dentist Name _____

3. Are you in any discomfort or pain at this time? ..... YES NO

4. Are you satisfied with the appearance of your teeth? ..... YES NO

5. Are you able to eat and chew foods satisfactorily? ..... YES NO

6. Do you have headaches, earaches or neck pain? ..... YES NO

7. Have you ever had any problems associated with any previous dental care? ..... YES NO

If YES, please explain

_____

_____

Do you now have or have you had any of the following? Please indicate yes with an (X)

( ) Teeth sensitive to cold/ hot/ sweet	( ) Bad breath	( ) Use chewing gum
( ) Bleeding gums	( ) Unpleasant taste	( ) Difficulty opening jaw
( ) Food impaction	( ) Periodontal (gum) treatment	( ) Do you fear treatment
( ) Clenching or grinding	( ) Orthodontic treatment (braces)	( ) Do you brush daily
( ) Burning of tongue/ mouth	( ) Endodontic treatment (root canal)	( ) Do you floss daily
( ) swelling or lump in mouth	( ) Complications with extraction	( ) Do you use mouthwash
( ) Blisters on lips/ mouth	( ) Use chewing tobacco	( ) Fluoride supplements
( ) Clicking/ popping of the jaw joint	( ) Smoke cigarettes, pipe, cigar, marijuana	( ) Use denture adhesive

Medical History

In the following questions circle YES or NO. Your answers are for our records only and will be considered confidential.

THESE FACTS HAVE DIRECT BEARING ON YOUR DENTAL HEALTH.

1. Are you in good general health? ..... YES NO

2. Has there been any change in your health within the past year? ..... YES NO

3. Your last physical examination was on (approximate date)_____

4. Are you now under the care of a physician? ..... YES NO

   If so, what are the condition(s) being treated? _____

5. The name, address and phone # of your physician _____

   _____

   Pharmacy Name_____Phone# (_____)_____

6. Have you ever had any serious illness or operation? ..... YES NO

   If so, please list illness/operation with date (year)_____

7. Have you been hospitalized or had a serious illness within the past five (5) years? ..... YES NO

   If so, what was the problem? _____

8. Do you have or have had any of the following diseases or problems?

a. Rheumatic fever or rheumatic heart disease..... YES NO
b. Congenital heart lesions, damaged heart valves, valve replacement..... YES NO
c. Heart murmur..... YES NO
d. Cardiovascular disease (heart trouble, heart attack, coronary blockage, coronary stents, arteriosclerosis, bypass surgery)..... YES NO
1) Do you have pain in your chest upon exertion? ..... YES NO
2) Are you ever short of breath after mild exercise? ..... YES NO
3) Do your ankles swell? ..... YES NO
4) Do you get short of breath when you lie down, or do you require extra pillows when you sleep? .. YES NO
5) Do you have a cardiac pacemaker? ..... YES NO
e. Stroke ..... YES NO
f. High blood pressure ..... YES NO
Low blood pressure ..... YES NO
g. Allergies or hay fever..... YES NO
h. Sinus trouble..... YES NO
i. Asthma, bronchitis or emphysema (circle which one)..... YES NO
j. Hives or skin rash..... YES NO
k. Fainting spells or seizures..... YES NO
l. Diabetes (controlled/uncontrolled)..... YES NO
1) Do you have to urinate (pass water) more than six (6) times a day? ..... YES NO
2) Are you thirsty much of the time? ..... YES NO
3) Does your mouth frequently become dry? ..... YES NO
m. Hepatitis (A, B, C), Jaundice or liver disease? ..... YES NO
n. Arthritis..... YES NO
o. Inflammatory rheumatism (painful swollen joints)..... YES NO
p. Joint replacement..... YES NO
q. Stomach ulcers..... YES NO
r. Kidney trouble..... YES NO
s. Tuberculosis..... YES NO
t. Do you have a persistent cough or cold? ..... YES NO
u. Frequent diarrhea or blood in your stools? ..... YES NO
v. Immune deficient disease..... YES NO
w. Venereal disease (syphilis, gonorrhea, HPV)..... YES NO
x. Psychiatric treatment or emotional disturbance..... YES NO
y. Hyper or hypothyroidism..... YES NO
z. Osteoporosis..... YES NO
aa. Cancer or malignancy..... YES NO
bb. Glaucoma..... YES NO
cc. Herpes, fever blisters, cold sores..... YES NO
dd. Other_____

9. Have you had abnormal bleeding associated with extractions, trauma or surgery? ..... YES NO
   a. Do you bruise easily? ..... YES NO
   b. Have you ever required a blood transfusion? ..... YES NO
   If so, explain the circumstances_____
10. Do you have any blood disorder such as anemia or sickle-cell? ..... YES NO
11. Have you had surgery or radiation treatment for a tumor, growth or other condition of your head or neck? ..... YES NO
12. Are you taking any drug or medicine? ..... YES NO

Name /Type of drug	Dosage	How many times per day?

13. Are you taking any of the following:
   a. Antibiotics..... YES NO
   b. Anticoagulants (blood thinners) ..... YES NO
   c. Medicine for high blood pressure..... YES NO
   d. Cortisone or steroids..... YES NO
   e. Sedative, tranquilizer..... YES NO
   f. Antihistamines..... YES NO
   g. Aspirin..... YES NO
   h. Insulin or diabetes drug..... YES NO
   i. Digitalis or drugs for heart trouble..... YES NO
   j. Nitroglycerin..... YES NO
   k. Oral contraceptive or other hormonal therapy (estrogen) ..... YES NO
   l. Osteoporosis drug - now or in the past (such as Zometa, Aredia, Fosamax, Actonel, Boniva, Reclast)..... YES NO
   m. Vitamins or other nutritional supplements..... YES NO
14. Are you allergic or have you reacted adversely to:
   a. Local anesthetics (lidocaine, novocaine)..... YES NO
   b. Antibiotic(s) (Penicillin or specify other_____)..... YES NO
   c. Sulfa drugs..... YES NO
   d. Barbiturates, sedatives, or sleeping pills..... YES NO
   e. Aspirin or ibuprofen..... YES NO
   f. Iodine..... YES NO
   g. Codeine or other narcotics..... YES NO
   h. Latex..... YES NO
   i. Adhesive tape (skin reaction)..... YES NO
   j. Other_____

15. Have you or a family member ever had an unusual reaction from being put to sleep for surgery? ..... YES NO
16. Have you ever required unusually large amounts of local anesthetic for medical or dental treatments?..... YES NO
17. Do you have any disease, condition or problem not listed above that you think the doctor should know about? ..... YES NO

If so, please explain_____

_____

18. Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation? YES NO
19. Are you wearing contact lenses? ..... YES NO
20. Do you drink alcohol? ..... YES NO

If so, how much and how often? _____

21. Do you smoke or use tobacco? ..... YES NO

If so, how much and how often? _____

22. Do you use or have you used recreational/street drugs? ..... YES NO

Women

23. Are you pregnant? ..... YES NO
24. Do you any problems associated with your menstrual period? ..... YES NO
25. Are you nursing? ..... YES NO

Responsibility and Consent for Treatment

I hereby authorize and request the performance of dental services for myself or for whom I am acting as legal guardian. I also give my consent to any advisable and necessary dental procedures, medications or anesthetics to be administered by the attending dentist or by his supervised staff for diagnostic purposes or dental treatment. I understand and acknowledge that I am financially responsible for the services provided for myself or the above named patient, regardless of insurance coverage.

To the best of my knowledge the information provided on this form is accurate and truthful.

If you had difficulty reading or understanding any of the questions, please make this known to the dentist.

_____ _____

Signature of Patient or Guardian **Date**

_____ _____

Signature of Dentist **Date**

Notice of Privacy Practices for Protected Health Information

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!

With your consent, the practice is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Example of uses of your health information for treatment purposes:
A nurse obtains treatment information about you and records it in a health record. During the course of your treatment, the doctor determines a need to consult with another specialist in the area. The doctor will share the information with such specialist and obtain input.

Example of use of your information for payment purposes:
We submit a request for payment to your dental/health insurance company. The dental/health insurance company requests information from us regarding medical care given. We will provide information to them about you and the care given.

Example of use of your Information for Health Care Operations:
We obtain services from our insurers or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credentialing, medical review, legal services, and insurance. We will share information about you with such insurers or other business associates as necessary to obtain theses services.

Your Health Information Rights
The health record we maintain and billing records are the physical property of the practice. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office. We are not required to grant the request but we will comply with any request granted;
- Request that you be allowed to inspect and obtain a copy of your health record and billing record-you may exercise this right by delivering the request in writing to our office;
- Appeal a denial of access to your protected health information except in certain circumstances;
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office;
- File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information;
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office. An accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care;
- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office; and,
- Revoke authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.

If you want to exercise any of the above rights, please contact us at (518) 563-6666, in person or in writing, during normal hours. We will provide you with assistance on the steps to take to exercises your rights.

Our Responsibilities

The practice is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice of our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request; and
- Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact us at (518) 563-6666.

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office. You may also file a complaint by mailing it or e-mailing it to the Secretary of Health and Human Services whose street address and e-mail address is:

The U.S. Department of Health and Human Services
200 Independence Avenue Southwest
Washington, D.C. 20201
Toll Free: 1-877-696-6775
http://www.hhs.gov/about/referist.html

- We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the practice.
- We cannot, and will not, retaliate against you for filing a complaint with the Secretary.

Other Disclosures and Uses

Notification

Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

Communication with Family

Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

Food and Drug Administration (FDA)

We may disclose to the FDA your protected health information relating to adverse events with respect to products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Workers Compensations

If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

Public Health
As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Abuse & Neglect
We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

Correctional Institutions
If you are an inmate of a correctional institution, we may disclose to the institution, or its agents, your protected health information necessary for your health and the health and safety of other individuals.

Law Enforcement
We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecutions, or to the extent an individual is in the custody of law enforcement.

Health Oversight
Federal laws allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

Judicial/Administrative Proceedings
We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with our consent, or as directed by a proper court order.

Other Uses
Other uses and disclosures besides those identified in this Notice will be made only as otherwise authorized by law or with your written authorization and you may revoke the authorization as previously provided.

Notice of Privacy Practices for Protected Health Information

I _____, hereby acknowledge that I have received a copy of this practice's Notice of Privacy Practices. I have been given the opportunity to ask any questions I may have regarding this Notice.

_____ _____

Signature **Date**

PATIENT DISCLOSURE INSTRUCTIONS

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (**check all that may apply**):

❑ Home telephone _____

- ❑ O.K. to leave message with detailed information
- ❑ Leave message with call-back number only

❑ Written communication

- ❑ O.K. to mail to my home address
- ❑ O.K. to mail to my work/office address
- ❑ O.K. to fax the number indicated

❑ Work Telephone_____

- ❑ O.K. to leave message with detailed information
- ❑ Leave message with call-back number only

❑ Other (Fax/Cell, etc.) _____

- ❑ _____

I allow you to give my clinical information to or answer questions from (**check all that may apply**);

- ❑ Spouse _____
- ❑ Parent _____
- ❑ Child _____
- ❑ Other (specify) _____
- ❑ Dentists _____
- ❑ Physicians _____
- ❑ None

_____ _____
Patient Signature Date

_____ _____
Print Name Birth date

CANCELLATION POLICY

Our goal is to provide quality dental care to all our patients in a timely manner.
No-shows, late arrivals, and cancellations inconvenience not only our providers, but our other patients as well. Please be aware of our policy regarding missed appointments.

Our office requests **a 2 business day** cancellation notice prior to all scheduled appointments. Cancellation must be cleared with our staff. Please do not leave a voicemail without following up. This will allow us to offer your appointment to another patient. Failure to do so will result in a $60.00 cancellation fee, which must be paid prior to rescheduling the failed appointment.

By signing this form, you are acknowledging the cancellation policy and accepting responsibility.

Signature: _____ **Date:** _____