FIFE DENTAL PATIENT REGISTRATION FORM

How did you hear about our office? (circle one) Internet Friend/Referral Drove By Insurance Co. Other _____

If referred by a friend or co-worker, please print their name _____

Please complete the following confidential information: PLEASE PRINT CLEARLY

Patient (or responsible party, if patient is a minor)

Last Name	First Name	Home Phone	Cell Phone

Address	City	State	Zip

Birth Date	Employer	Work Phone/ext.	Occupation	Driver's License

Social Security Number	Email Address	Sex
		☐ Male ☐ Female

Spouse ☐ Male ☐ Female

Last Name	First Name	Home Phone	Cell Phone

Address	City	State	Zip

Birth Date	Employer	Work Phone/ext.	Occupation	Driver's License

Child (if child is the patient) ☐ Male ☐ Female

Last Name	First Name	Birth Date

Address	City	State	Zip

Dental Insurance

Insurance Name	Address / City/ State / Zip

Name of Policy Holder	Policy Holder's Social Security #	Member #	Group #

Policy Holder's Employer	Policy Holder's Date of Birth

Additional Insurance Name	Address	Policy Holder's Social	Group #

Person to contact in case of emergency:

Name _____ Address _____

Phone _____

Is another member of your family a patient at our practice? ☐ Yes ☐ No

Name _____

Name _____ DOB_____ Health History Alert _____

MEDICAL / DENTAL HISTORY

Are you experiencing dental pain or discomfort?..... YES NO
Are you in good health?..... YES NO
Has there been a change in your general health within the past year?..... YES NO
Are you under the care of a physician?..... YES NO
If so, what condition is being treated?..... YES NO

Physician's Name _____ Phone # _____

DO YOU SMOKE OR USE ANY TOBACCO PRODUCTS? YES NO
WOMEN: ARE YOU PREGNANT OR THINK YOU MIGHT BE? YES NO

PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY:

❑ AIDS	❑ DIABETES	❑ HIVES
❑ ALCOHOLISM	❑ DRUG DEPENDENCY	❑ HYPOGLYCEMIA
❑ ANEMIA	❑ EATING DISORDER	❑ JAUNDICE
❑ ANGINA	❑ EMPHYSEMA	❑ KIDNEY/LIVER DISEASE
❑ AARTIFICIAL HEART VALVE	❑ EPILEPSY	❑ MITRAL VALVE PROLAPSE
❑ ARTIFICIAL JOINTS	❑ FAINTING/DIZZY SPELLS	❑ NIGHT SWEATS
❑ ARTHRITIS/RHEUMATISM	❑ FEVER BLISTERS/COLD SORES	❑ OSTEOPOROSIS
❑ ASTHMA	❑ GAG EASILY	❑ PARALYSIS
❑ BIRTH CONTROL	❑ GLAUCOMA	❑ PROLONGED BLEEDING
❑ BLOOD PRESSURE-HIGH	❑ HEADACHES-FREQUENT	❑ PSYCHIATRIC TREATMENT
❑ BLOOD PRESSURE-LOW	❑ HEART ATTACK	❑ RHEUMATIC FEVER
❑ BLOOD THINNERS	❑ HEART MURMUR	❑ SICKLE CELL DISEASE
❑ BRUISE EASILY	❑ HEMOPHILIA	❑ SINUS TROUBLE
❑ CANCER	❑ HEPATITIS	❑ STROKE
❑ CHEMOTHERAPY/RADIATION	❑ HEREDITARY DISEASE	❑ TUBERCULOSIS
❑ CONGENITAL HEART DISEASE	❑ HIV POSITIVE	❑ TUMORS
❑ DEAF	❑ HERPES	❑ VENEREAL DISEASE

HAVE YOU HAD ANY OTHER SERIOUS ILLNESS? ❑ YES ❑ NO PLEASE DESCRIBE _____

DRUGS / MEDICATIONS

ARE YOU ALLERGIC TO OR HAVE YOU HAD A BAD REACTION TO:

❑ ASPIRIN	❑ IODINE	❑ NARCOTICS	❑ LATEX
❑ BARBITURATES	❑ KEFLEX	❑ PENICILLIN	❑ OTHER ALLERGIES-DESCRIBE _____
❑ CODEINE	❑ LOCAL ANESTHETIC	❑ SULFA	_____
❑ ERYTHROMYCIN	❑ NITROUS OXIDE	❑ TETRACYCLINE	_____

PLEASE LIST ANY MEDICATIONS TAKEN WITHIN THE LAST 6 MONTHS _____

_____

PLEASE LIST ANY MEDICATIONS YOU ARE TAKING NOW _____

REASON _____

CONSENT: As the undersigned, I hereby authorize Doctor to, after thorough explanation, take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a diagnosis of my dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated (after they are discussed with me) and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered.

All proceeds of insurance are assigned to the Doctor when applicable, but without the Doctor assuming responsibility for the collection of those claims. If the insurance company does not pay my claim within 60 days after it is submitted, it is understood that I pay the balance of my account and that I contact my insurance company regarding settlement. It is agreed that payment will not be delayed or withheld because of pending insurance coverage.

If I do not pay the entire balance, or if insurance is unpaid after 60 days, a billing charge will be added to my account. The billing charge will be at a periodic rate of 1.5% per month (or a minimum charge of $2.00 for a balance under $100) which is an annual percentage rate of 18%. In case of default of payment, I agree to pay any and all costs in collecting this account, including but not limited to attorney fees and court costs. I understand that, where appropriate, credit reports may be obtained.

Signature of Patient (Parent) _____ Date _____

Relationship to Patient _____ Date _____ Witness_____

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Appointment attendance policy

- We ask that all scheduled appointments be cancelled at least 24 hours before the scheduled appointment time.
    - If a patient does not cancel a dental appointment at least 24 before scheduled appointment time, it will be considered a broken appointment.
    - Should an individual accumulate three broken appointments during their time as a patient at Fife Dental, the office can consider this to be grounds for patient dismissal from the practice. Being dismissed as a patient would mean that we would no longer be able to provide for your dental care.
    - A parent or guardian of minors must be present and remain with your child until they are seated for their appointment. The parent or guardian must remain on the premises until the child's appointment is finished.

Consent for use and disclosure of health information

- By signing this form, you are consenting to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. You retain the right to read our Notice of Privacy Practices before you sign this consent form. A copy is available upon request, and it is encouraged and recommended to be read before signing this consent form. If a change is made to our notice of privacy practices, we will issue a revised copy which will contain the changes. These changes may apply to any of your protective health information that we maintain.

You may obtain a copy of the latest Notice of Privacy Practices by contacting our office using the information listed above.

- You have the right to revoke this consent at any time by giving our office written notice of your revocation. Please understand that revocation of this consent will not affect any action taken before receipt of your revocation. Revoking your consent may result in our declination to treat you or to continue treating you after you revoke your consent.
- We take your privacy very seriously in this office and will not disclose any information without your consent. Should you wish to give permission for our office to discuss your health history or any medical concerns with someone else, please provide their names and relationship to you below. If left blank, no one besides the patient will have access to any protected healthcare information.

I wish to give the following individual(s) permission to discuss my protected health information with Fife Dental:

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

- By signing below, I have had the full opportunity to read and consider the appointment attendance policy, consent for use and disclosure of health information. I understand that, by signing this form, I am giving consent to Fife Dental to use my protected health information to carry out treatment, payment activities, and healthcare operations.

Patient name: _____

Signature: _____ Date: _____

If the patient is a minor or is unable to sign consent for themselves, please fill out the information below:

_____

Parent/Guardian/Personal Representative's Name Relationship to patient