PATIENT REGISTRATION

First Name: _____ Last Name: _____ Middle Initial: _____
Preferred Name: _____

Patient Information:

Address: _____ Address 2:_____
City: _____State/Zip: _____
Home Phone: _____ Work Phone: _____ ext: ___ Mobile Phone: _____
Sex: ○ Male ○ Female Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed
Birth Date: _____ Age: ____ Soc. Sec: _____ Drivers Lic #: _____
Email: _____ ○ I would like to receive correspondence via email
Employment Status: ○ Full-time ○ Part-time ○ Retired ○ Unemployed ○ Disabled
Student Status: ○ Full-time ○ Part-time How did you hear about our office? _____
Preferred Dentist: _____ Previous Dentist: _____
Preferred Pharmacy: _____ Last Dental Visit: _____
Pharmacy # (if known): _____
Emergency Contact: _____ Emergency Contact #: _____

Responsible Party (if someone other than patient):

First Name: _____ Last Name: _____Middle Initial: __
Address: _____ Address 2: _____
City, State, Zip: _____
Home Phone: _____Work Phone: _____ext:____ Cell Phone: _____
Birth Date: _____ Soc. Sec: _____ Drivers Lic #:_____
○ Responsible Party is also Primary Insurance Policy Holder
○ Responsible Party is also Secondary Insurance Policy Holder

Primary Insurance Information:

Name of Insured: _____ Relationship to Insured: ○ Self ○ Spouse
○ Child ○ Other
Insured Soc. Sec #: _____ Insured Birth Date: _____
Employer: _____
Employer Address: _____
City, State, Zip: _____
Insurance Company: _____
Insurance Company Address: _____
City, State, Zip: _____

Secondary Insurance Information:

Name of Insured: _____ Relationship to Insured: ○ Self ○ Spouse
○ Child ○ Other
Insured Soc. Sec #: _____ Insured Birth Date: _____
Employer: _____
Employer Address: _____
City, State, Zip: _____
Insurance Company: _____
Insurance Company Address: _____
City, State, Zip: _____

FINANCIAL POLICY

We are happy to bill your insurance as a courtesy. However, the patient receiving service (or their legal guardian) is ultimately responsible for all fees incurred. We require you to pay the "patient portion" at the time of service which may include a deductible, co pay, and/or a percentage of each procedure. If your insurance has not made payment in full within 2 months of treatment, you are responsible for paying the balance, and your insurance company will then reimburse you. We accept cash, checks, VISA, and MasterCard. We also offer financing through Care Credit.
Please initial: _____

CANCELLATION POLICY

If you are running late please call the office. We may be able to see you at the time you arrive, or we may need to reschedule to be fair to those patients who arrive on time.

If you need to cancel or reschedule your appointment, kindly give us at least 24 hours notice. This allows us a chance to help other patients during the time we had reserved for you. Wasted appointment time leads to higher dental care cost for everyone. Therefore, in order to control dental costs for our patients we must charge a non-refundable cancellation fee of $25 to $50 which will not be covered by your insurance. Failure to give us notice three times may result in dismissal from the practice.
Please initial: _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES

you may refuse to sign this acknowledgement

I acknowledge that I have received a copy of this office's Notice of Privacy Practices. I understand that, by signing below, I am authorizing members of SeaSide Dental Center and their employees to disclose information about my past and future dental treatment to my insurance company and to other dental professionals and physicians as needed so that I may be provided with the best comprehensive care possible. I also authorize SeaSide Dental Center to leave messages regarding appointment times and purpose on an answering machine, voicemail, or with persons answering the phone at the numbers I give them to reach me. I understand that I will be required to sign a release form to give permission for SeaSide Dental Center to share information with anyone other than those specified above.
Please initial: _____

CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION BY E-MAIL/TEXT

I consent to transmit the following protected health information related to my health records and health care treatment:
Information related to the scheduling of meetings or other appointments, information related to billing and payment, completed forms, including forms that may contain sensitive confidential information, information of clinical nature, including discussion of personal material relevant to my treatment, my health record, in part or in whole, or summaries of material from my health record.

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this authorization at any time in writing.
Please initial: _____

I verify that I have read, understand, and agree to all of the above policies.

SIGNED _____

DATE _____

Office Use Only: Unable to obtain due to:
○ Refusal ○ Communication Barrier ○ Emergency Situation ○ Other_____

MEDICAL HISTORY

Patient Name: _____Date of Birth: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ○ Yes ○ No
If yes, please explain: _____
Have you ever been hospitalized or had a major surgery? ○ Yes ○ No
If yes, please explain: _____
Have you ever had a serious head or neck injury? ○ Yes ○ No
If yes, please explain: _____
Are you on a special diet? ○ Yes ○ No
If yes, please explain: _____
Do you take, or have you ever taken, Phen-Fen or Redux? ○ Yes ○ No
If yes, please explain: _____
Have you taken Zometa, Aredia or any other Bisphosphonate drugs? ○ Yes ○ No
If yes, please explain: _____
Do you use any controlled substances? ○ Yes ○ No
If yes, please explain. Include type and frequency: _____
Do you drink alcohol? ○ Yes ○ No
If yes, how many drinks per week on average? _____
Do you use tobacco of any kind? ○ Yes ○ No
If yes, please explain. Include type and frequency: _____

Women:

Pregnant/trying to get pregnant? ○ Yes ○ No
Taking oral contraceptives? ○ Yes ○ No
Nursing? ○ Yes ○ No

Are you allergic to the following?

□ Sulfa □ Penicillin □ Codeine □ Acrylic □ Metal □ Latex □ Local Anesthetics □ Aspirin
□ Other If yes, please explain: _____

Is premedication required for dental appointments? □ Yes □ No If yes, why?
_____

Please circle all that apply now or in the past:

AIDS/HIV Positive	Cortisone Medicine	Hemophilia	Radiation Treatments	Yellow Jaundice
Alzheimer's Disease	Diabetes	Hepatitis A	Recent Weight Loss	
Anaphylaxis	Drug Addiction	Hepatitis B or C	Renal Dialysis	
Anemia	Easily Winded	Herpes	Rheumatic Fever	
Angina	Emphysema	High Blood Pressure	Rheumatism	
Arthritis/Gout	Epilepsy or Seizures	High Cholesterol	Scarlet Fever	
Artificial Heart Valve	Excessive Bleeding	Hives or Rash	Shingles	
Artificial Joint	Excessive Thirst	Hypoglycemia	Sickle Cell Disease	
Asthma	Fainting Spells/Dizziness	Irregular Heartbeat	Sinus Trouble	
Blood Disease	Frequent Cough	Kidney Problems	Spina Bifida	
Blood Transfusion	Frequent Diarrhea	Leukemia	Stomach/Intestinal Disease	
Breathing Problems	Frequent Headaches	Liver Disease	Stroke	
Bruise Easily	Genital Herpes	Low Blood Pressure	Swelling of Limbs	
Cancer	Glaucoma	Lung Disease	Thyroid Disease	
Chemotherapy	Hay Fever	Mitral Valve Prolapse	Tonsillisis	
Chest Pains	Heart Attach/Failure	Osteoporosis	Tuberculosis	
Cold Sores/Fever Blisters	Heart Murmur	Pain in Jaw Joints	Tumors or Growths	
Congenital Heart Disorder	Heart Pacemaker	Parathyroid Disease	Ulcers	

Convulsions	Heart Trouble/Disease	Psychiatric Care	Venereal Disease

MEDICAL HISTORY (PAGE 2)

Have you ever had any serious illness not listed on the previous page? ○ Yes ○ No
If yes, please explain:

_____
_____
_____

Are you currently taking any medications? ○ Yes ○ No
If yes, please list and give the reason for taking each one. Please include vitamins and herbal remedies.

_____
_____
_____

Questions, comments, or anything else you would like us to know about you:

_____
_____
_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in my medical status.

SIGNATURE OF PATIENT AND/OR LEGAL GUARDIAN (IF PATIENT IS UNDER 18):

X _____

DATE: _____

Medical Information Release Form
(HIPAA release form)

SeaSide Dental Center

Name: _____ Date of Birth _____/_____/_____

Release of Information

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

- Spouse: _____
- Child(ren): _____
- Other: _____

This Release of Information will remain in effect until terminated by me in writing.

Authorization for Release/Use of Protected Health Information in the Form of Photos, Radiographs, and Electronic Images

Your photos and x-rays are part of your diagnostic and clinical record and are considered to be protected health information under federal HIPAA Privacy Laws.

We make use of radiographs (x-rays), photographs, and digital images. These images may be used for diagnosis, documentation, reference, teaching, and research publication. Some cases that present exceptional results, particularly remarkable smiles, or interesting situations may be utilized for demonstration, education or advertising to potential and existing patients in our office either in print media, social media, television, on digital media and on our webpage. In some instances, you may be recognizable in some of these images.

By initialing and signing this form, you are authorizing us and releasing us from any liability resulting from the use/release of such images. Your authorization and release to use images will in no way affect the quality of your results in our office. We do our best to provide exceptional dentistry to all patients.

___ I authorize the use of my images where my face is identifiable
___ I authorize the use of my images where only my teeth are identifiable
___ I authorize the use of my radiographs

The purpose of this request to release and/or disclose the PHI described above is for personal reasons. I understand that I have the right to revoke this Authorization, in writing, at any time by notifying the office above. Such revocation will not affect actions taken by the requesting person prior to the date he or she received the written revocation. I also understand information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and will no longer be protected by this rule.

I understand that my health care provider cannot condition treatment on whether I sign this authorization. This Authorization will expire at such time that:

___ I determine that I no longer wish for my images to be used and I revoke this authorization in writing; or
___ The following date: _____

_____ _____
Signature of Patient Date