Patient Registration

Full Name: ______________________________

Date of Birth: ____________ Soc. Security # ______________

Home Address: ______________________________

City: ______________ State: __________ Zip Code: ________

Home Phone: ______________ Cell: ______________

Email: ______________________________

Marital Status: Single Married Divorced Other: ____________

Work Phone: ______________________________

Employer: ______________________________

Occupation: ______________________________

Employer Address: ______________________________

City: __________ State: ______ Zip Code: ________

Sex: Male or Female

Drivers Lic. # ______________________________

Emergency Contact: ______________________________

Phone: ______________________________

Relationship to patient: ______________________________

Is Patient a minor? Yes or No

Name of Parent/Legal Guardian: ______________________________

Parent/Legal Guardian Date of Birth: ______________________

Dental Benefits Plan Information

Primary Dental Insurance Name: ______________________

Claims Address: ______________________________

City: ______________ State: __________ Zip Code: ________

ID Number/SSN: ______________________________

Relationship to Policy Holder: ______________________

Provider Service Phone: ______________________

Employer: ______________________________

Policy Holder: ______________________________

Policy Holder Date of Birth: ______________________

Secondary Dental Insurance Name: ______________________

Claims Address: ______________________________

City: ______________ State: __________ Zip Code: ________

ID Number/SSN: ______________________________

Relationship to Policy Holder: ______________________

Provider Service Phone: ______________________

Employer: ______________________________

Policy Holder: ______________________________

Policy Holder Date of Birth: ______________________

Medical History

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 to the best of your knowledge.

Are you under a physician's care now? Yes/No If yes, please explain: ______________________

Have you recently been Hospitalized? Yes/No If yes, please explain: ______________________

Have you ever had a serious head or neck injury? Yes/No If yes, please explain: ______________________

Are you taking any medications, pills or drugs? Yes/No PLEASE LIST MEDICATIONS: ______________________

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Have you ever responded adversely to medical or dental treatment? Yes/No

If yes, please explain: ______________________________

Do you take or have you taken, Phen-fen or Redux? Yes/No If yes, please explain: ______________________

Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates? Yes/No

If yes, please specify: ______________________________

Are you on a special diet? Yes/No If yes, please specify: ______________________________

Do you use controlled substances? Yes/No If yes, please specify: ______________________________

Do you use tobacco? Yes/No

Women, Are you:

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

Do you have, or have you had any of the following?

AIDS/HIV	Yes No	Genital Herpes	Yes No	Shingles	Yes No
Alzheimer's Disease	Yes No	Glaucoma	Yes No	Sickle Cell Disease	Yes No
Anaphylaxis	Yes No	Hay Fever	Yes No	Sinus Trouble	Yes No
Anemia	Yes No	Heart Attack/Failure	Yes No	Spina Bifida	Yes No
Angina	Yes No	Heart Murmur	Yes No	Stomach/Intestinal Disease	Yes No
Arthritis/Gout	Yes No	Heart Pace Maker	Yes No	Stroke	Yes No
Artificial Heart Valve	Yes No	Heart Trouble/Disease	Yes No	Swelling of Limbs	Yes No
Artificial Joint	Yes No	Hemophilia	Yes No	Thyroid Disease	Yes No
Asthma	Yes No	Hepatitis A	Yes No	Tonsillitis	Yes No
Blood Disease	Yes No	Hepatitis B or C	Yes No	Tuberculosis	Yes No
Blood Transfusion	Yes No	Herpes	Yes No	Ulcers	Yes No
Breathing Problems	Yes No	High Blood Pressure	Yes No	Venereal Disease	Yes No
Bruise Easily	Yes No	Hives or Rash	Yes No		
Cancer	Yes No	Hypoglycemia	Yes No		
Chemotherapy	Yes No	Irregular Heart Beat	Yes No		
Chest Pains	Yes No	Kidney Problems	Yes No		
Cold Sores	Yes No	Leukemia	Yes No		
Congenital Heart Disorders	Yes No	Liver Disease	Yes No		
Convulsions	Yes No	Low Blood Pressure	Yes No		
Cortisone Medicine	Yes No	Lung Disease	Yes No		
Diabetes	Yes No	Mitral Valve Prolapse	Yes No		
Drug Addiction	Yes No	Pain in Jaw Joints	Yes No		
Emphysema	Yes No	Parathyroid Disease	Yes No		
Epilepsy or Seizures	Yes No	Psychiatric Care	Yes No		
Excessive Bleeding	Yes No	Radiation Treatments	Yes No		
Fainting Spells	Yes No	Renal Dialysis	Yes No		
Frequent Cough	Yes No	Rheumatic Fever	Yes No		
Frequent Diarrhea	Yes No	Rheumatism	Yes No		
Frequent Headaches	Yes No	Scarlet Fever	Yes No		

Have you ever had any serious illness not listed above? Yes/No

If yes, please explain: ______________________

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Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other ______________________________

I understand that the information I have given today is correct to the best of my knowledge. I authorize Towne Dental to perform all necessary dental services that I may need and have consented to. I authorize Towne Dental to share all necessary information with (patient's) dental insurance company to process my dental benefit claims. I hereby authorize any applicable payment to be made directly to Dr Jose Ramirez and associates at Towne Dental. I understand that providing incorrect information can be dangerous to my (the patient's) health. I understand that it is my responsibility to inform the dental office of any changes in medical status. (__________ Initials)

Signature of Patient (Legal Guardian) ______________________________ Date ______________________

FINANCIAL CONSENT FORM

I, ____, understand that I am financially responsible to cover for my dental treatment.

If applicable, Towne Dental will help verify and bill my dental insurance on my behalf. I understand that having an active dental insurance policy does not guarantee coverage for some dental treatments and that there may be out-of-pocket fees that I am responsible for.

If I am using dental insurance to help cover for my treatment, I can ask Towne Dental to submit a“pre-determination request” which will provide a precise estimate of costs and coverage. This process can take up to several weeks and delay my dental treatment.

I have read and understood all the above.

______________________________ ______________________________

Printed Patient Name Patient's Date of Birth

______________________________ ______________________________

Patient or Guardian Signature Date

PATIENT ACKNOWLEDGEMENT OF

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received (or have been offered) a copy of this office's Notice of Privacy Practices. By signing this form, you are giving this office your consent to use and disclose health information about you for treatment, payment, and health care operation purposes.

_______________________________ Patient Name Printed

_______________________________ Patient Date of Birth

_______________________________ Patient or Guardian Signature

_______________________________ Date

_______________________________ Witness

_______________________________ Date

For Office Use Only

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

_______ Individual refused to sign
_______ Communications barriers prohibited obtaining the acknowledgments
_______ An emergency situation prevented us from obtaining acknowledgements
_______ Other (Please Specify):

_______________________________ Staff Name

_______________________________ Date