PATIENT REGISTRATION

Patient Information:

Date of Birth: _____

First Name: _____ Middle Initial: _____

Last Name: _____ Preferred Name: _____

Address: _____ Address 2: _____

City, State, Zip: _____

Primary Phone: _____ ○ Cell ○ Home. ○ Work

Secondary Phone: _____ ○ Cell ○ Home. ○ Work

E-mail: _____ Sex: ○ Female ○ Male

Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Social Security #: _____ Drivers Lic#: _____

Responsible Party:

(If not the patient, person financially responsible for them. Usually the owner of the insurance policy.)

Relation to Patient: _____ Date of Birth: _____

First Name: _____ Middle Initial: _____

Last Name: _____ Preferred Name: _____

Address: _____ Address 2: _____

City, State, Zip: _____

Primary Phone: _____ ○ Cell ○ Home. ○ Work

Secondary Phone: _____ ○ Cell ○ Home. ○ Work

Social Security #: _____ Drivers Lic#: _____

Emergency Contact:

First Name: _____ Last Name: _____

Phone Number: _____

Pharmacy:

Name of Pharmacy: _____ Phone Number: _____

Address: _____ Adress 2: _____

City, State, Zip: _____

TIME 10:43 AM

DATE 7/12/2011

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

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 operation? ◯ 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 If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No

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

Are you on a special diet? ◯ Yes ◯ No

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Women: Are you

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

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: _____

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

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

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

Comments: _____

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 medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Racine Dental Care

215 Racine Dr. Suite 102
Phone Number: *(910) 332-0687*
Fax Number: *910) 332-0689*
Contact Person: Dr. Safia Azizi, D.M.D.

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient name: _____ Phone number: _____

Address: _____

I authorize the professional office of my dentist named above to release health information identifying me [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services] under the following terms and conditions:

I. **Detailed description of the information to be released:** Complete health record including but not limited to, diagnosis, lab test results, treatment and billing records for all conditions.

II. **To whom may the information be released [name(s) or class(es) of recipients]:** I authorize for the information detailed in section **I** of this document to be shared with specialists, insurance and pharmacists necessary for the advancement of my treatment. I'd like to include those listed below (if applicable).

Relationship to patient: _____ Name: _____

Relationship to patient: _____ Name: _____

III. **The purpose(s) for the release:** I understand that all information detailed in section **I** authorizes those mentioned in section **II** to facilitate my treatment.

IV. **Expiration date or event relating to the individual or purpose for the release:** This is authorization to share my information is valid all, past, present and future periods.

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a signed letter telling us that your authorization is revoked. Send this letter to the office contact person listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Dated: _____ Patient signature: _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to patient: _____ Name: _____

Source of Authority: _____

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Dr. Safia Azizi's Notice of Privacy Practices.

Patient name: _____

Signature: _____ Date: _____

Racine Dental Care's
Appointment & Financial Agreement

Appointments:

We make every effort to stay on or ahead of schedule. A lot goes preparing for your appointment. We reserve your appointment time especially for you so that you and the other patients are not kept waiting unnecessarily. Missed appointments hurt you, other patients who may need emergency care, and our practice. You are welcomed and encouraged to request a copy of your appointment agreement.

I. As a courtesy we send a reminder of your appointment but we are not required to. **It is your responsibility to remember your appointment.** Always notify us of any changes in your contact information.

II. If you are are late for your appointment we may need to reschedule.

III. If you need to change or reschedule, we require **at least 2 business days** notice prior to your appointment. We reserve the right to assess a **$50.00 fee** to patients who missed their appointment or cancel without proper notice.

IV. Minors cannot be seen if not accompanied by a guardian at the time of their appointment. This guardian must be able to make payment as well as decisions in case of an emergency.

V. As a courtesy we will file your insurance, but we are not required to. If you have any changes to your insurance you must notify us at least 2 business days prior to your appointment. This allows us to prepare for changes in coverage prior to your visit that may affect your payment due.

We cannot guarantee same day insurance verification. If that is the case, full payment will be due at the time of your visit. Once insurance payment has been received you will be reimbursed any monies due.

V.I If you have any questions about the cost for your upcoming treatment, please refer to your treatment estimate or contact our office **prior to** your appointment. **Payment is collected at the time of your appointment.**

I agree to the terms outlined above for my upcoming appointment at Racine Dental.

Patient/Guardian Signature: _____ **Date:** _____

Finances:

We pride ourselves in being honest and transparent with our patients. Therefore we provide you with our financial policy to insure no misunderstandings arise regarding the payment of your dental care. We strongly suggest you read through all of it in order to avoid any upset in the future. You are welcomed and encouraged to request a copy.

I. **Full payment of treatment is due no later than the date treatment is completed.** This includes deductibles and copays and any pending balance.

III. Cash, Personal Checks, Visa, MasterCard, American Express, and Discover are acceptable forms of payment.

Checks returned to our office from your financial institution are subject to a **$25.00 returned check fee**. This fee covers the bank service charge.

IV. For your convenience we also accept CareCredit. This third party allows you to make monthly payments to them for treatment with deferred interest for a certain amount of time for qualifying treatment. For more information on CareCredit ask our front desk or go on their website: www.carecredit.com.

V. Any insurance you provide is an agreement between you and your insurance provider. We are not a party to this agreement. **Any estimate of what your insurance may cover is not a guarantee of coverage.**

Your insurance will have final say on what will be payed, stipulations, limitations, and downgrades. We are not required to re-file a denied claim. **Therefore any balance and/or unpaid claims by your insurance is your responsibility after 30 days.** The patient is required to resolve any issues in a timely fashion in order to re-file a claim.

V.I We will notify you of any balance either via text, phone call, or by mailing a statement. It is your responsibility to notify us of any change in your contact information in order to receive notifications and avoid collections. **Any balance past 90 days will go to collections.**

I agree to the terms outlined above for my upcoming appointment at Racine Dental.

Patient/Guardian Signature: _____ **Date:** _____

DENTAL HISTORY

Patient Name: _____ Birth Date: _____

Racine Dental Care considers your dental history an important tool in treating you today and in future visits. Thank you for taking the time in answering the following questions so we can help you achieve optimum oral health for a lifetime.

1. Purpose for today's Visit: _____
2. How long has it been since your last dental cleaning/exam? _____

Circle the appropriate answer. If you do not know the correct answer, please write "don't know ", on the line after the question.

3. If you have replacement teeth from extractions, (examples: bridges, dentures, implants, partials) are you happy with the fit? YES NO
4. Would you like to learn about permanent tooth placement? YES NO
5. Do you clench or grind your teeth? YES NO
6. Are your teeth sensitive to: Cold Hot Sweets Biting Pressure
7. Does food get caught in between your teeth? YES NO
8. Do your gums bleed or hurt? YES NO
9. Do you experience dry mouth? YES NO
10. How often do you brush your teeth? _____
11. How often do you use dental floss? _____
12. Are any of your teeth loose, shifted, or chipped? YES NO
13. Are you happy with your smile and the color of your teeth? YES NO
14. Do you feel your breath is offensive at times? YES NO
15. Do you have a family history of gum or teeth problems? YES NO
16. Do you or have you previously: Smoked Dip Tobacco Drink Alcohol Used Other Drugs
17. Have you ever had a "deep cleaning" or gum surgery? YES NO
18. Are you anxious about going to the dentist? YES NO
19. Is there anything you would like to share with us that would help us ensure your visit with us is a pleasant experience? _____

_____

20. What time would work best to accommodate your needs?

Morning: _____ Mid Morning: _____ Afternoon: _____ After 5PM: _____

21. Referral source to our office: _____

I certify that the above information is complete and accurate.

Patient/Guardian's Signature: _____ Date: _____

Authorization to Release Health Information – Compound Release

Name of Patient: _____ Date of Birth:_____

_____ is authorized to release PHI about the above named patient in the following manner and/or to selected persons.

CHECK EACH PERSON/ENTITY APPROVED TO RECEIVE INFORMATION.	**CHECK TYPE OF INFORMATION THAT CAN BE GIVEN TO PERSON/ENTITY ON THE LEFT IN THE SAME SECTION.**	
☐ Voice Mail	☐ Results of lab tests/x-rays ☐ Other:	
☐ Other(s): (provide name and phone number) _____ _____	☐ Financial	☐ Medical
☐ Email communication-Provide email address* _____ *For email communication to occur, please accept the disclosure below.	☐ Financial ☐ Medical	☐ Appointment reminders ☐ Breach notification
☐ Text communication – Provide number * _____ *For text communication to occur, accept the disclosure below.	☐ Appointment reminder ☐ Other: _____	
☐ * **Acknowledge for email and/or text communication** I understand that if information is *not* sent in an encrypted (secure) manner, there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.		
☐ Photo of patient received by patient or legal guardian ☐ Photo taken by staff (Example: pre/post procedure) ☐ Other: _____	☐ May be posted at the office ☐ May be posted on website ☐ Other:_____	

Patient's Rights:

- I have the right to revoke this authorization at any time in person or in writing.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.
- I understand released information may include a communicable disease diagnosis such as HIV or a diagnosis related to mental health or substance abuse.

This authorization will remain in effect until revoked by the patient in writing.

Signature of Patient or Personal Representative: _____ Date: _____

*Description of Personal Representative's Authority (attach necessary documentation)

REVOKED

How: ☐ in person on _____. (date) If in person, signature is required.

Signature of Patient or Personal Representative: _____

☐ in writing (place copy in patient's file)

Authorization to Release Health Information

Patient Information:

Name of Patient: _____ Date of Birth: _____

Address: _____

City, State, Zip: _____ Phone: _____

_____ **may release the following information on behalf of the patient:**

(Name of the entity)

- ☐ Entire record
- ☐ Financial records
- ☐ Office visit notes
- ☐ Marketing*
- ☐ Psychotherapy notes – if this box is checked only psychotherapy notes may be released.
- ☐ Diagnostic studies (list): _____
- ☐ Other (list): _____

*Financial compensation is received for this communication.

Entity or person who will receive the information:

Name: _____

Address: _____

City, State, Zip: _____ Phone: _____

☐ **Send the information electronically. Email address:** _____

☐ **Acknowledge for email and/or text communication** I understand that if information is *not* sent in an encrypted (secure) manner, there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.

This authorization shall be in effect until the information has been forwarded as requested, until the course of treatment is complete, or until revoked by the patient in writing.

Patient's Rights:

- I have the right to revoke this authorization at any time in person or in writing.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I may refuse to sign this authorization and that my treatment will not be conditioned on signing.
- I understand released information may include a communicable disease diagnosis such as HIV or a diagnosis related to mental health or substance abuse.

This authorization will remain in effect until revoked by the patient in writing.

Signature of Patient or Personal Representative: _____ Date: _____

*Description of Personal Representative's Authority (attach necessary documentation)

REVOKED

How: ☐ in person on _____. (date) If in person, signature is required.

Signature of Patient or Personal Representative: _____

☐ in writing (place copy in patient's file)