PATIENT REGISTRATION

Patient Information **Referred By** _____

First Name _____ Last Name _____ Middle Initial _____

Address _____

City, State, Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Birth Date _____ Social Security # _____ E-Mail _____

Occupation _____

Responsible Party (if different than above information)

First Name _____ Last Name _____ Middle Initial _____

Address _____

City, State, Zip _____

Birth Date _____ Social Security # _____

Home Phone _____ Work Phone _____ Cell Phone _____

Primary Dental Insurance Information (Please provide insurance card to be copied)

Name of Ins. Company _____

Member ID _____ Group # _____

Name of Ins. Policyholder _____ Employer's Name _____

Policyholder's Soc. Security # _____ Policyholder's Birth Date _____

Secondary Dental Insurance Information (Please provide insurance card to be copied)

Name of Ins. Company _____

Member ID _____ Group # _____

Name of Ins. Policyholder _____ Employer's Name _____

Policyholder's Soc. Security # _____ Policyholder's Birth Date _____

Patient's Primary Physician's Name _____ Phone Number _____

Patient's Preferred Pharmacy Name _____ Phone Number _____

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 If yes, please explain: _____

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 _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Compton and Broomhead Dental Center
901 Fran Lin Pkwy
Munster, IN 46321

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow- up among the multiple health care providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third party payers.
3. Conduct normal health care operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operation. I also understand that you are not required to agree to my requested restriction, but if you agree then you are bound to abide by such restrictions.

Patient Name (print) _____

Relationship to Patient _____

Signature _____ Date _____

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

We make every effort to contact our patients before appointments.
Circle preferred method/methods of choice; phone, letter, e-mail, and/or text

Patient Name _____ Date of Birth _____

Address _____

Home # _____ May we leave a message? Yes _____ No _____

Work # _____ May we leave a message? Yes _____ No _____

Cell # _____ May we leave a message? Yes _____ No _____

E-Mail _____ May we send an e-mail? Yes _____ No _____

May we send an appointment reminder text message? Yes _____ No _____

May we leave a message that you need pre-medication? Yes _____ No _____

May we leave a message that you have a dental appointment? Yes _____ No _____

FOR OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on the *Notice of Privacy Practices* but was unable to do so as documented below.

Date _____ Reason _____ Initials _____

COMPTON AND BROOMHEAD
DENTAL CENTER

Financial Guidelines

We are committed to your treatment being successful. Please understand that payment of your account is part of your treatment. We will always seek to inform you of all fees involved in your treatment and to get permission before any treatment is done. The following section outlines our financial guidelines. Please feel free to ask our financial manager any and all questions you might have.

OPTION 1: Cash, Personal Check, Visa, MasterCard, Discover or American Express We offer a courtesy of 5% off (10% for those patients age 65 or older) when services are paid in full with cash, check or personal credit card on the day the treatment is rendered.

OPTION 2: 50% down One half of total charges is due at the time of service. The remaining balance is due in two monthly payments.

OPTION 3: Care Credit We have teamed with Care Credit (outside financing) in order to be able to offer extended payment options. We will go over the payment options when we discuss your specific treatment plan.

INSURANCE: It is the patient's responsibility to know their insurance benefits. (PPO, DMO, etc.) We accept and file your insurance as a courtesy to you. We are not contracted with any insurance companies. The amount not covered is due when services are rendered. The patient is responsible for payment on all unpaid claims and balances within 30 days.

INSURANCE RELEASE:

I authorize Compton and Broomhead Dental Center to release any information, including the diagnosis and the records of any treatment or examination rendered to me and/or my minor child during the period of such dental care, to third party payers and/or health practitioners. I understand that my dental carrier may pay less than the actual bill for services. I agree to be responsible for all services rendered on my behalf or my dependents.

_____ for _____ Date _____

Signature Patient

ACCOUNT AGREEMENT:

I have had all my questions answered and agree to Compton and Broomhead Dental Center's financial guidelines. In the event that this account becomes delinquent, I agree to pay a finance charge of 1.5% per month or 18% annually. Further, if the undersigned patient or responsible party's account becomes delinquent, the undersigned will pay all legal fees or other costs incurred by our office in the collection of this account.

Signature _____ Date _____