REGISTRATION FORM

Main Contact Number: ____________________

PATIENT INFORMATION

Patient's name: First ______________ Last ______________ Marital status: ☐ Single ☐ Married ☐ Child

Address: ______________ Birth date: ______________ Age: ____

City: ______________ State: ____ Zip Code: ______________ Sex: ☐ Male ☐ Female

Email Address: ______________ Can we reach you by this email address? ☐ YES ☐ NO

Social Security no.: ______________ Home phone no.: ______________ Cell phone no.: ______________

Occupation: ______________ Employer: ______________ Work phone no.: ______________

Alternate contact number: ______________ Relationship: ______________

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Name of person responsible for bill: ______________ Birth date: ______________

Address: ______________ Home phone no.: ______________

City: ______________ State: ____ Zip Code: ______________ Occupation: ______________

Employer: ______________ Business address: ______________ Business Phone Number: ______________

Please indicate primary insurance: ______________

Subscriber's name: ______________ Subscriber's S.S. no.: ______________ Birth date: ______________

Group no.: ______________ Policy no.: ______________ Primary insurance phone no.: ______________

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other: ______________

Please indicate secondary insurance: ______________

Subscriber's name: ______________ Subscriber's S.S. no.: ______________ Birth date: ______________

Group no.: ______________ Policy no.: ______________ Primary insurance phone no.: ______________

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other: ______________

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address): ______________

Relationship to patient: ______________ Phone Number: ______________

Address: ______________ City: ______________ State: ____ Zip Code: ______________

GETTING TO KNOW YOU

Whom may we thank for referring you to our office? ______________

Is another member of your family or relative/friends a patient at our office? Name: ______________

Relationship: ______________

CONSENT FOR TREATMENT/FINANCIAL RESPONSIBILITY:

This is to certify that I, Undersigned: 1) consent to the performing of the dental procedures agreed to be necessary or advisable, including the use of local anesthetic as indicated: 2) consent to releasing information to my insurance company: 3) agree to pay the fees associated with the dental procedures, including the award of thirty percent collection agency fees, all reasonable attorney's fees, at trial and on appeal, as determined by the court for the legal efforts necessary to obtain the fees.

Insurance and Financial Policy

Our primary goal is not to allow the cost of treatment to prevent you from receiving the care that you need.

Insurance

We charge what is usual and customary for our area. We will assist you with your benefit eligibility before treatment to help you calculate your costs and maximize your insurance. We will be sensitive to your financial circumstances and do everything possible to help you achieve oral health for you and/or your family.

Ultimately, however, You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. We are happy to submit the claims necessary to see that you receive the full benefits of your coverage; however, we cannot guarantee any estimated coverage. Because the insurance policy is an agreement between you and the insurance company, we ask that all patients be directly responsible for all charges. Please know that we will do everything possible to see that you receive the full benefits of your policy by electronically filing your claim the day of your appointment. If there are any complications, we will assist you with any information you may need. Please remember that your insurance policy is a contract between you and your insurance provider. We will, as a courtesy, bill your insurance to help you receive the maximum benefit under your policy. It is your responsibility to provide all necessary insurance identifications, understand your eligibility and notify us immediately of any changes. It's also your responsibility to ensure that our office is a participant with your insurance plan.

- All Co-Pays and Deductibles will be due at the time of service
- Pre-estimates can be submitted on your behalf, please understand they are simply an ESTIMATION of patient cost

Do you have dental insurance that we may file on your behalf and accept assignment of payment? ☐ Yes ☐ No

Payment Options

We make payments convenient as possible by accepting Cash, Check, Master Card, Visa and American Express. Payments can be made also online. If you prefer to make a payment online via our patient portal, please request for a temporary ID/Password to access your patient portal account.

- All services without insurance submission are due in full the day of treatment
- The practice may condition receipt of treatment upon execution of this consent.We offer a 5% discount to any bill over $500.00 when paid in full with cash or check the day of service.
- External financial options available through CareCredit/Lending Point (0% interest up to 6 months and above for any treatment above $500.00)
- A $35 fee will be applied to all returned checks
- Balances over 90 days will be turned over to an external collection company
- Account must be paid in full prior to each 6-month cleaning and exam appointment

Agreement

I understand and fully agree that I am responsible for my account balance. I agree that if turned over to a collection source, I will be responsible for fee above and beyond my account which may include attorney fees, along with external companies. I understand that if my account becomes overdue or uncollected, it can result in cancelled appointment and dismissal from the practice. Lastly, if insurance is involved, I take full responsibility for any following up on any disputes I may have with their payment schedule.

Patient's name: First ______________ Last ______________ Birth date: ______________

Parent/Guardian name (please print) ______________________________

Patient/Guardian Signature: ______________________________ Date: ______________

Health History Form

Patient's Name: LAST ______________ FIRST ______________ Date of Birth: ____________

If you are completing this form for another person, what is your relationship to that person?

Relationship: ______________ Your Name: ______________

DENTAL INFORMATION

What was the date of your last dental exam: ______________ Date of last dental x-rays: ______________

What was done at that time? ______________

	Yes	No
Do your gums bleed when you brush or floss?	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐
Does food or floss catch between your teeth?	☐	☐
Is your mouth dry?	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐
Have you had orthodontic (braces) treatment?	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐
Are you currently in dental pain or discomfort?	☐	☐
Do you have any clicking, popping, or discomfort in the jaw?	☐	☐
Do you grind or clench your teeth?	☐	☐
Do you get sores or ulcers in your mouth?	☐	☐
Do you wear dentures or partial dentures?	☐	☐
Have you had a serious injury to your head or mouth?	☐	☐

What is the reason for your visit today? ______________

MEDICAL INFORMATION

	Yes	No
Are you now under the care of a physician?	☐	☐

Physician/Facility: ______________ Phone Number: (include area code) ______________

Address/City/State: ______________

Date of last physical exam: ______________

	Yes	No
Are you in good health?	☐	☐
Are you currently being treated for any conditions?	☐	☐

If yes, what conditions are being treated?

Have you had a serious illness, operation or been hospitalized in the past 5 years? ☐ ☐

If yes, what was the illness or problem?

Are you taking or have you recently taken any prescription or over the counter medications? ☐ ☐

If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:

Condition:

Yes	No

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease? ☐ ☐

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? ☐ ☐

	Yes	No
Do you use tobacco? (smoking/snuff/chew/vape)	☐	☐

If so, how interested are you in stopping?

☐ VERY ☐ SOMEWHAT ☐ NOT INTERESTED

	Yes	No
Do you use recreational drugs?	☐	☐
Do you drink alcoholic beverages?	☐	☐

If yes, how much do you typically drink in a week?

Joint Replacement: Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? ☐ ☐

Date: Surgeon: If yes, have you had any complications?

WOMEN ONLY:

	Yes	No
Are you pregnant	☐	☐

Number of Weeks:

	Yes	No
Are you currently taking birth control pills or hormone replacement?	☐	☐
Are you nursing?	☐	☐

Allergies: Are you allergic to or have you had a reaction to:

Specify Type of Reaction:

	Yes	No	Specify Type of Reaction
Local Anesthetics	☐	☐	
Penicillin or other Antibiotics	☐	☐	
Codeine or other Narcotics	☐	☐	
Latex (Rubber)	☐	☐	
Metals	☐	☐	

	Yes	No	
Sulfa Drugs	☐	☐	______
Barbiturates/Sedatives/Sleeping Pills	☐	☐	______
Food/Milk	☐	☐	______
Other Allergies	☐	☐	______

____

	Yes	No
Has your physician recommended you take a premedication before dental treatment?	☐	☐

Name of physician making recommendation: ______________________________

Phone: (include area code) ______________________________

Please check your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No
Cardiovascular Disease	☐	☐
Angina	☐	☐
Congestive Heart Failure	☐	☐
Congenital Heart Disease	☐	☐
Coronary Artery Disease	☐	☐
Damaged or Replaced Heart Valves	☐	☐
Heart Attack	☐	☐
Low Blood Pressure	☐	☐
High Blood Pressure	☐	☐
Abnormal Bleeding	☐	☐
Anemia	☐	☐
Blood Transfusion If Yes, Date:______	☐	☐
Hemophilia	☐	☐
AIDS or HIV infection	☐	☐
Arthritis	☐	☐
Autoimmune Disease	☐	☐
Rheumatoid Disease	☐	☐
Systemic lupus (erythematosus)	☐	☐
Asthma	☐	☐
Emphysema	☐	☐
Sinus Trouble	☐	☐
Cancer/Chemo/Radiation Treatment	☐	☐
Chest Pain Upon Exertion	☐	☐

	Yes	No
Chronic Pain	☐	☐
Diabetes (Type I or II)	☐	☐
Eating Disorder	☐	☐
G.E. Reflux/Heartburn	☐	☐
Ulcers	☐	☐
Thyroid Problems	☐	☐
Stroke	☐	☐
Glaucoma	☐	☐
Hepatitis, Jaundice or Liver Disease	☐	☐
Epilepsy	☐	☐
Fainting Spells/Seizures	☐	☐
Neurological Disorders If Yes, Specify:______	☐	☐
Sleep Disorder	☐	☐
Mental Health Disorders Specify: ______	☐	☐
Recurrent Infections Type infections:______	☐	☐
Kidney Problems	☐	☐
Night Sweats	☐	☐
Osteoporosis	☐	☐
Persistent Swollen Glands in Neck	☐	☐
Severe Headaches/Migraines	☐	☐
Severe or Rapid Weight Loss	☐	☐
Sexually Transmitted Disease	☐	☐
Excessive Urination	☐	☐

	Yes	No
Do you have a disease, condition or problem not listed above that we should know about?	☐	☐

If yes, please explain:

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

______________________________ ______________

Signature of Patient/Legal Guardian Date

HIPAA Compliance
Patient Consent Form

Our notice of privacy practices provides information about how we may use or disclose protected health information

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be

By signing this form, I understand that:

- We may disclose patient health information to insurance providers for the purpose of payment or health care operations.
- In connection with treatment, we may disclose patient health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.
- We may disclose patient health information as necessary to comply with State Workers' Compensation Laws.
- We may disclose patient health information to notify or assist in notifying a family member, or another person responsible for patient care about patient medical condition or in the event of an emergency.
- As required by law, we may disclose patient health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.
- We may disclose patient health information in the course of any administrative or judicial proceeding.
- We may disclose patient health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.
- We may disclose patient health information to coroners or medical examiners.
- We may disclose patient health information to organizations involved in procuring, banking, or transplanting organs and tissues.
- We may disclose patient health information to researchers conducting research that has been approved by an Institutional Review Board.
- It may be necessary to disclose patient health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.
- We may disclose patient health information for military, national security, prisoner and government benefits purposes. In the event that Thompson Family Dental at Nora is sold or merged with another organization, patient health information/record will become the property of the new owner.

May we phone, email or send a text to you to confirm appointments? ☐ Yes ☐ No

May we leave a message on your voicemail at home or cell phone? ☐ Yes ☐ No

May we discuss your medical condition with anyone? ☐ Yes ☐ No

If yes, please list name(s) allowed & relationship:

____

____

Patient's name: First ________________ Last ________________ Birth date: ____________

Parent/Guardian name (please print) ____________________________

Patient/Guardian Signature: ________________________________ Date: ____________

Flouride Treatment Consent Form - Adult

Patient's Name: LAST ____________ FIRST ____________ Date of Birth: ____________

Fluoride is effective in preventing and reversing the early signs of dental caries (tooth decay). Researchers have shown that there are several ways through which fluoride achieves its decay preventive effects. Fluoride incorporates into the tooth structure making it stronger resulting in teeth that are more resistant to acid attacks. Fluoride also acts to repair or remineralize areas in which acid attacks have already begun.

Fluoride application is an important part of the comprehensive preventative program at Thompson Family Dental. Fluoride not only helps prevent new decay from developing, it also helps protect existing dental work so that fillings are replaced less frequently, decreases sensitivity, makes teeth last longer and saves you money. Fluoride is most effective when applied after the dental cleaning and all the plaque and build up have been removed from the tooth's surface.

☐ I give consent to apply flouride treatment TWICE per year.
I agree that if my insurance company does not pay for the flouride application that I am responsible for payment. I am aware that it is my responsibility to check benefits for service coverage.

☐ I give consent to apply flouride treatment ONCE per year.
I agree that if my insurance company does not pay for the flouride application that I am responsible for payment. I am aware that it is my responsibility to check benefits for service coverage.

☐ I DECLINE flouride treatment.

______________________________ ______________

Signature of Patient/Legal Guardian Date

Flouride Treatment Consent Form - Child

Patient's Name: LAST ____________ FIRST ____________ Date of Birth: ____________

Fluoride is effective in preventing and reversing the early signs of dental caries (tooth decay). Researchers have shown that there are several ways through which fluoride achieves its decay preventive effects. Fluoride incorporates into the tooth structure making it stronger resulting in teeth that are more resistant to acid attacks. Fluoride also acts to repair or remineralize areas in which acid attacks have already begun.

Fluoride application is an important part of your child's comprehensive preventative program at Thompson Family Dental. Fluoride not only helps prevent new decay from developing, it also helps protect existing dental work so that fillings are replaced less frequently, decreases sensitivity, makes teeth last longer and saves you money. Fluoride is most effective when applied after the dental cleaning and all the plaque and build up have been removed from the tooth's surface. It is our office protocol to apply fluoride varnish at each routine care appointment for your child to receive maximum benefit.

☐ I give consent to apply flouride treatment TWICE per year.
I agree that if my insurance company does not pay for the flouride application that I am responsible for payment. I am aware that it is my responsibility to check benefits for service coverage.

☐ I give consent to apply flouride treatment ONCE per year.
I agree that if my insurance company does not pay for the flouride application that I am responsible for payment. I am aware that it is my responsibility to check benefits for service coverage.

☐ I DECLINE flouride treatment.

____________________________________ ____________

Signature of Patient/Legal Guardian Date