PATIENT REGISTRATION

Date: _____

PATIENT INFORMATION

Name _____

Address _____

City _____ State _____ Zip _____

Sex _____ Age _____ Birthdate _____

Marital status _____ Student status - Circle one : FT PT N/A

Preferred confirmation method: Phone/cell_____ Email: _____

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone _____

Whom may we thank for referring you? _____

In case of emergency, who should be notified? Name : _____ Phone: _____

Who is your primary care physician? _____

PRIMARY INSURANCE

Person responsible for account _____

Relation to patient _____ Birthdate _____ ID# _____

Address _____ Phone _____ SS# _____

City _____ State _____ Zip _____

Person responsible employed by: _____ Occupation _____

Business Address _____ Phone _____

Insurance Company _____

Group number _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? Circle One: Yes No

Subscriber Name _____ Relation to patient _____ Birthdate _____

Address if different from patient _____ Phone _____

City _____ State _____ Zip _____

Subscriber employed by _____ Business phone _____

Insurance company _____ SS# _____

Group # _____ ID/Subscriber # _____

1. Before treatment can be rendered, adequate radiographs of the teeth and mouth must be taken.
2. In this office we use local anesthetic and other methods of pain control to make our patients more comfortable while receiving dental treatment.
3. Unless otherwise arranged, payment for professional service is required *on the day the treatment is rendered.* With prior approval, on certain extended procedures and treatment, payment plans can be arranged.
4. Please give at least 48 hours notice if you cannot keep your appointment, otherwise, you will be billed for services scheduled.

Consent for Procedure

This is to certify that I, undersigned, consent to the performing of the dental and oral surgery procedures agreed to be necessary or advisable, including the use of general or local anesthetic as indicated and I will assume responsibility for fees associated with those procedures.

Patient's(Parent) Signature _____ Date _____

HEALTH HISTORY

Patient Name:_____ Today's date:_____

Email : _____ Birth Date: _____

I. CIRCLE APPROPRIATE ANSWER (leave blank if you do not understand question):

1 Yes No Is your general health good?

2 Yes No Has there been a change in your health within the last year?

_____

3 Yes No Have you been hospitalized or had a serious illness in the last three years?
If yes, why? _____

4 Yes No Are you being treated by a physician now? For what? Who is your physician?

_____

Date of last dental exam _____ Date of last medical exam _____

5 Yes No Have you had problems with prior dental treatment?

6 Yes No Are you experiencing dental pain now?

7 Yes No Are you taking any medications?
If yes, please list: _____

_____

_____

8 Yes No Allergies to: drugs, foods, medications, latex?

_____

_____

_____

II. HAVE YOU EXPERIENCED:

9 Yes No Chest pain

10 Yes No Shortness of breath

11 Yes No Persistent cough, coughing up blood?

12 Yes No Bleeding problems, bruising easily?

13 Yes No Sinus problems?

14 Yes No Difficulty swallowing?

15 Yes No Frequent vomiting, nausea?

16 Yes No Dizziness?

17 Yes No Headaches?

18 Yes No Fainting spells?

19 Yes No Blurred vision?

20 Yes No Seizures?

21 Yes No Dry mouth?

22 Yes No Jaundice

23 Yes No Joint pain, stiffness?

III. DO YOU HAVE OR HAVE YOU HAD:

24 Yes No Heart murmur?

25 Yes No Rheumatic fever?

26 Yes No Heart disease, heart attack, heart defects, or other aortic disease?

27 Yes No Stroke, hardening of the arteries?

28 Yes No High blood pressure?

29 Yes No Asthma,TB, emphysema, other lung disease?

30 Yes No Hepatitis, other liver disease?

31 Yes No Stomach problems, ulcers?

32 Yes No AIDS?

33 Yes No Tumors, cancer?

34 Yes No Anemia?

35 Yes No Herpes/cold sores?

36 Yes No Kidney, bladder disease?

37 Yes No Thyroid, adrenal disease?

38 Yes No Diabetes?

IV. DO YOU HAVE OR HAVE YOU HAD:

39 Yes No Psychiatric care?

40 Yes No Radiation treatments?

41 Yes No Chemotherapy?

42 Yes No Prosthetic heart valve?

43 Yes No Artificial Joint?

44 Yes No Pacemaker?

V. ARE YOU USING:

45 Yes No Recreational drugs?

46 Yes No Tobacco? Chewing or smoking?

47 Yes No Alcohol?How much?_____

48 Yes No Soda? How much?_____

VI. WOMEN ONLY:

49 Yes No Are you or could you be pregnant or nursing?

50 Yes No Taking birth control pills?

VII. ALL PATIENTS:

51 Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form?

If so, please explain: _____

_____

_____

To the best of my knowledge, I have answered every question completely and accurate. I will inform my dentist of any change in my health and/or medication.

Patient's signature: _____ Date: _____

Recall review:

Patient's signature: _____ Date: _____

Patient's signature: _____ Date: _____

REILLY FAMILY DENTAL LLC

1018 E. King Rd., Tomahawk, WI 54487 (715) 453-7071

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: PATIENT GIVING CONSENT

Name: _____BirthDate_____

Address: _____Telephone # _____

Section B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protect ted health information that we maintain.

You may obtain a copy or our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Pat Johnson
Telephone: (715) 453-7071
Address: PO Box 287 Tomahawk, WI 54487

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I,_____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name (Parent/Guardian): _____

Relationship to patient: _____

YOU ARE ENTITILED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart

REVOCATION OF CONSENT

I revoke my consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my consent.

Signature: _____ _____Date: _____