PATIENT REGISTRATION

PATIENT INFORMATION **DATE**_____

Patient Name_____ DOB_____
Last First MI

□ Male □ Female □ Married □ Single □ Child □ Other_____

Phone: (Home) _____ (Work)_____ext_____ (Cell)_____

Address_____
Street City State Zip

Employer_____ Occupation_____

E-mail Address_____

RESPONSIBLE PARTY INFORMATION (*If different from patient information)*

Name_____ DOB _____

Phone: (Home) _____ (Work) _____ (Cell)_____

CONSENT

The undersigned hereby authorizes Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with (Name of Patient) _____and further authorize and consent that Doctor choose and employ such assistance as deemed fit. I also understand that the use of anesthetic agents embodies a certain risk.

Patient or Responsible Party

Signature _____ Date _____

Relationship to Patient _____

PHILIP D. WRIGHT, DMD PLLC

Acknowledgement of Receipt
Of Notice of Privacy Practices

Patient Name: _____

I have received a copy of the Notice of Privacy Practices for the above named practice.

_____ _____
Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ❑ An emergency existed & a signature was not possible at the time.
- ❑ The individual refused to sign.
- ❑ A copy was mailed with a request for a signature by return mail.
- ❑ Unable to communicate with the patient for the following reason:
  _____
- ❑ Other:_____
  _____

Prepared By _____

Signature _____

Date _____

WELCOME! We are delighted to welcome you to our practice and are pleased that you chose us to serve your dental needs. Our dental staff is committed to providing you with the best care possible. We believe the more you know about our practice and financial policies, the better we can serve you. Please initial each paragraph below, in the provided space after reading.

FINANCIAL POLICY

_____If you do not have dental insurance, payment is due at the time services are rendered. For those procedures requiring multiple appointments, we request that half of the fee be paid when treatment begins, and the remaining half will be due upon completion of the treatment. We do not offer payment plans. For your convenience, we accept Visa, MasterCard, check, and cash. A $25 fee will be charged for any checks that are returned for non-sufficient funds.

_____**Any account balance remaining unpaid after 60 days, will I incur interest at the rate of 5% per month. If the balance remains unpaid after 90 days, the account will be turned over to a national collection agency, or to an attorney for collection.** In the event the account must be turned over for collections, the patient/guardian will incur these fees.

DENTAL INSURANCE

_____As a courtesy to our patients, we will gladly file your primary dental insurance for you. If you are planning to file with a secondary policy, we will be happy to provide you with the necessary information to do so. **Please keep in mind that your insurance is a contract between you, your employer, and your insurance company and we are NOT a party to that contract**. Our relationship is with you, not your insurance company. For those procedures requiring multiple appointments, we request that one-half (1/2) of the fee be paid when the treatment begins, and the remaining half will be due upon completion of the treatment. We will accept pre-authorized claims as the second half of payment. **Failure of your insurance company to reimburse or respond within 30 days will result in us billing you directly. Once payment on your claim has been received, it is your responsibility to pay any remaining balance on your account. Account balances that remain unpaid after 60 days will incur interest at the rate of 5% per month. After 90 days, any outstanding balance will be turned over to a national collection agency or to an attorney for collection. In the event that an account must be turned over for collections, the patient/guardian will incur any reasonable attorney fees.**

APPOINTMENTS

____**OUR OFFICE REQUIRES 24 HOURS NOTICE IF YOU ARE UNABLE TO KEEP YOUR APPOINTMENT. FAILURE TO DO SO WILL RESULT IN A $40 CHARGE PER HOUR AS SCHEDULED. DUE TO OUR OFFICE BEING CLOSED ON FRIDAY, THURSDAY IS CONSIDERED THE "24 HR. NOTICE PERIOD" FOR ANY APPOINTMENTS SCHEDULED ON A MONDAY. AFTER THREE (3) FAILED APPOINTEMENTS (INCLUDES "NO-SHOWS" AND CANCELLED APPOINTMENTS WITHOUT PROPER NOTICE), YOU WILL BE DISMISSED FROM THE PRACTICE.**

** This is to certify that I, the undersigned, agree to accept full responsibility for the payment of all fees. I have read, understood, and agreed to the Financial Policy stated above, and know that it may be revised at any time.

_____

Patient/Guardian Signature **Date**

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 _____

Authorization for Release of Information – Compound Release

Name of Patient _____ Date of Birth _____

Philip D. Wright, DMD PLLC is authorized to release protected health information about the above named patient in the following manner and to identified persons.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
☐ Spouse (provide name and phone number) _____	☐ Financial ☐ Medical
☐ Parent (provide name and phone number) _____	☐ Financial ☐ Medical

☐ **Communications regarding appointments, treatment, and financial/insurance information are transmitted by phone, voicemail, email, and postcards (recall reminders only). If this is not your preference please notify us.**

☐ **Email communication-Provide email address*** _____

*In order for email communication to occur, please accept the disclosure below:

☐ For email communication I understand that if email is not sent in an encrypted manner there is a risk it could be accessed inappropriately. Radiographs and patient records are the only documents that will be sent in an encrypted manner. I still elect to receive email communication.

Patient Rights: I have the right to revoke this authorization at any time.

- 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..

The information is released at the patient's request and this authorization will remain in effect until revoked by the patient.

_____Date _____

Signature of Patient or Personal Representative

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

_____