Clear Creek
FAMILY DENTAL

# PATIENT REGISTRATION

First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name: _____

Address: _____ City/State/Zip Code: _____

Home Phone #: (____) _____

Birth Date: _____/_____/_____ Social Security Number: _____

Emergency Contact Name & #: _____ (____) _____

| Sex: | Marital Status: |
|---|---|
| ☐ Male<br>☐ Female | ☐ Married<br>☐ Single<br>☐ Widowed |

**Responsible Party (if someone other than the patient)**

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ City/State/Zip Code: _____

Home Phone #: (____) _____ Birth Date: _____/_____/_____ Soc Sec: _____

| **Primary Insurance Information** | **Secondary Insurance Information** |
|---|---|
| Subscriber Name: _____ | Subscriber Name: _____ |
| Subscriber ID/SSN: _____ | Subscriber ID/SSN: _____ |
| Subscriber DOB: _____/_____/_____ | Subscriber DOB: _____/_____/_____ |
| Relationship to Patient: | Relationship to Patient: |
| ☐ Self | ☐ Self |
| ☐ Spouse | ☐ Spouse |
| ☐ Child | ☐ Child |
| ☐ Other | ☐ Other |
| Employer: _____ | Employer: _____ |
| Insurance Company: _____ | Insurance Company: _____ |
| Insurance Co Ph #: (____) _____ | Insurance Co Ph #: (____) _____ |
| Group Number: _____ | Group Number: _____ |

# Clear Creek Family Dental 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 using, ????*

| | | |
|---|---|---|
| Are you under a physician's care now? | ❍ Yes ❍ No | If Yes: _____ |
| Have you ever been hospitalized or had a major operation? | ❍ Yes ❍ No | If Yes: _____ |
| Have you ever had a serious head or neck injury? | ❍ Yes ❍ No | If Yes: _____ |
| Are you taking any medications, pills, or drugs? | ❍ Yes ❍ No | If Yes: _____ |
| Do you take, or have you taken Phen-Fen or Redux? | ❍ Yes ❍ No | If Yes: _____ |
| Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? | ❍ Yes ❍ No | If Yes: _____ |
| Are you on a special diet? | ❍ Yes ❍ No | |
| Do you use tobacco? | ❍ Yes ❍ No | |
| Do you use controlled substances? | ❍ Yes ❍ No | If Yes: _____ |

Women: Are you... ❑ Pregnant/Trying to get pregnant? ❑ Nursing? ❑ Taking oral contraceptives?

Are you allergic to any of the following?

❑ Aspirin ❑ Penicillan ❑ Codeine ❑ Acrylic

❑ Metal ❑ Latex ❑ Sulfa Drugs ❑ Local Anesthesia

❑ Other? If Yes: _____

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

| | | | |
|---|---|---|---|
| AIDS/HIV Positive ❍ Yes ❍ No | Cortisone Medicine ❍ Yes ❍ No | Hemophilia ❍ Yes ❍ No | Radiatiom 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 |
| Arthrits/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 Problems ❍ 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 | Tonsilitis ❍ 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: _____

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:

**X** **Date:** _____

# ***CLEAR CREEK FAMILY DENTAL***

**I understand that, under the Health Insurance Portability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information will be used but not mandatory for me to sign in order 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 or indirectly.**
2. **Obtain payment from third party payers.**
3. **Conduct normal healthcare operations such as quality assessments and physician certifications.**

**I have been informed by this office of the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given a copy of this office's Privacy Practices prior to signing this consent. I understand that this organization has the right to change its' Privacy Practices from time to time and that I may contact this organization at any time at the above address to obtain a current copy.**

**I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that this organization is not required to agree to my requested restrictions, but if this organization does agree, then said organization is bound by such restrictions.**

**I, hereby understand that I may revoke this consent in writing at any time except to the extent this organization may have taken action relying on this consent.**

**Patient Name_____**
**Signature _____**
**Relationship to Patient_____**
**Date:_____**

# Insurance and Payment Disclaimer

- Payment for professional services is due at the time dental treatment is provided. Every effort will be made to provide a treatment plan that fits your timetable, budget, and gives you the best possible care.

  A 7% discount for payment in full at time of service with cash and a 5% discount for credit or debit card will be provided for our patients with no dental insurance coverage for amounts over $500. We are also excited to be able to provide third party financing through Care Credit, offering interest free financing for 6 or 12 months. *If Care Credit is used, a discount will not be applied.

- Insurance is submitted for your convenience. We will submit charges for dental work to your insurance company as long as we have received all of the needed information on the day of your appointment. It is very important that you be familiar with your insurance benefits. We will collect payment from you based on the estimated amount that your insurance is not expected to pay. By law your insurance company is required to pay/respond to each claim within 30 days of receipt. We file all insurance electronically so your insurance company should receive each claim within days of the treatment.

- You are responsible for any balance on your account after 90 days, whether insurance has paid or not. We will be glad to send a refund to you once insurance has issued us payment

I, (please print)_____ , have read and understand the above statements regarding the insurance and payment policy for Clear Creek Family Dental.

*Signature*:_____ *Date*:_____

# HIPAA Medical Information Release Form

Name: _____ Date of Birth: _____/____/_____

## Release of Information

**Please put the first and last name of the person/people you wish to release information to.**

☐ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

- Spouse_____
- Child(ren)_____
- Other_____

☐ Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

## Messages

Please call [ ]my home [ ] my work [ ] my cell Number:_____

**If unable to reach me (PLEASE CHECK ONE BOX):**

☐ You may leave me a detailed message.

☐ Please leave a message asking me to return your call.

The best time to reach me is (day)_____ between (time)_____

Signed: _____ Date: ____/____/_____

# SLEEP APNEA QUESTIONNAIRE

**❑ Have you been diagnosed with sleep apnea**

**❑ Do you currently use a CPAP Machine**