PATIENT REGISTRATION AND MEDICAL HISTORY

Phone: Home _____Work_____Cell_____

E-Mail_____

Patient_____
First Name Middle Initial Last Name Nick Name

Mailing Address_____

City_____State_____Zip Code_____

Sex: oM oF Age_____ Birthdate_____ Social Security #_____The reason we ask for your social security number is so we may verify and file your dental insurance. Without it we are unable to provide this service. If you do not wish to provide us with your social security number then you will have to pay your fee in full at the time of service and file your own dental insurance.

Employer_____Occupation_____

Who may we thank for referring you? _____

In case of emergency, who should be notified? _____Phone_____

Have you ever had any of the following? (**CHECK BOXES THAT APPLY**)

oHeart Murmur	oStroke	oSinus trouble
oDiabetes	oTuberculosis	oAsthma
oCancer	oThyroid Problems	oFainting spells
oSeizures	oA.I.D.S./H.I.V.	oHigh blood pressure
oArthritis	oPacemaker	oLow blood pressure
oGeneral Allergies	oHepatitis	oArtificial knee, hip or joint
oArtificial Heart Valves	oMitral valve Prolapse	oEpilepsy
oSwollen neck glands	oRheumatic Fever	oAnxiety or panic attacks
oSexually transmitted disease	oImmune Problems	oKidney trouble
oUlcers	oCardiovascular disease	oRespiratory problems
oPsychiatric Care	oChemical Dependency	oAnemia

oother_____

Are you allergic or have you had a reaction to:

oLocal anesthetics	oPenicillin	oNSAIDS
oAspirin	oCodeine	oOther_____
oIodine	oSulfa	

If you are taking any medicine including non-prescription medicine, please list.

_____

_____

The following question is for patients with heart murmurs, rheumatic heart disease, joint replacements, artificial plastic surgery or other known reasons that an antibiotic is needed before dental treatment and that you have been advised by your treating physician that you should be pre-medicated. **Are you pre-medicated?** oyes ono

(Women)
Are you pregnant? o yes o no Are you nursing? o yes o no Are you taking birth control pills? o yes o no

Signature_____ Date_____

DENTAL INSURANCE, ASSIGNMENT & RELEASE

Do you have dental insurance o yes o no
Dental Insurance company_____
Group/policy number_____
Insurance company phone #_____

Primary policy holder_____
their date of birth_____
their employer_____
Their Social Security or ID #_____

I assign benefits directly to Clark Endodontics LLC. I understand that my co-payment is an ESTIMATE based on the information provided by my insurance carrier. THIS IS NOT A GUARANTEE OF PAYMENT BY MY INSURANCE CARRIER. My carrier will process my claim based on the provisions of my policy and the current information from my employer. FILING INSURANCE CLAIMS IS A SERVICE PROVIDED WITHOUT CHARGE AND IN NO WAY RELIEVES ME OF RESPONSIBILITY FOR MY BILL. I AM AWARE THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY CARRIER.

_____ _____
Signature of Patient or Responsible Party **Date**

INFORMED CONSENT

I acknowledge that payment is due at the time of service. I understand that I am financially responsible for all fees including any collection costs, attorney cost and any court costs associated with the payment of fee for service. There will be a $30.00 charge for any returned checks.

The fee that is quoted is for the doctor's time and service, apart from the outcome.

I give permission to Clark Endodontics LLC to email unencrypted x-rays and/or correspondence to my dentist.

I have read and agree to the above consent.

_____ _____
Signature of Patient or Responsible Party Date

ACKNOWLEDGEMENT OF PRIVACY RIGHTS

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected Health Information. I understand that my information may be used or disclosed for treatment, payment or health care operations-which means for providing healthcare to me, the patient; handling billing and payment; and taking care of other health care operations.

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures pf my protected health information. I understand that I have the right to read the '*Notice'* before signing this agreement. If I ask, my provider with provide me with the most current *Notice of Privacy Practices*.

My signature below indicates that I have been given the chance to review such cop of the *Notice of Privacy Practices*. I have the right to revoke this consent in writing at any time, except to the extent that my provider has taken action relying on the consent.

Patient Name_____Signature_____

Date_____ Relationship to Patient _____