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

Are you allergic or have you had a reaction to:

oLocal anesthetics
oAspirin
oIodine
oPenicillin
oCodeine
oSulfa
oNSAIDS
oOther________________________

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

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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.

Any account NOT paid in full within 30 days of invoice date will be assessed a monthly late fee of $10.00.

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 copy 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.

Print Name__________________________________Signature____________________________________

Date______________________________ Relationship to Patient ________________________________