TIME 12:10 PM DATE 2/4/2015

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: [ ] Policy Holder [ ] Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

[ ] Responsible Party is also a Policy Holder for Patient [ ] Primary Insurance Policy Holder [ ] Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: [ ] Male [ ] Female Marital Status: [ ] Married [ ] Single [ ] Divorced [ ] Separated [ ] Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: [ ] I would like to receive correspondences via e-mail.

Section 2

Employment Status: [ ] Full Time [ ] Part Time [ ] Retired

Student Status: [ ] Full Time [ ] Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

Pager#

Cell Phone Number

Emergency Contact

Emergency Contact#

treatment

Primary Insurance Information

Name of Insured: Relationship to Insured: [ ] Self [ ] Spouse [ ] Child [ ] Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: [ ] Self [ ] Spouse [ ] Child [ ] Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

MEDICAL HISTORY

Patient Name ______________________ Nickname ____________ Age ______

Name of Physician/and their specialty ______________________

Most recent physical examination ______________ Purpose ______________

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD: YES NO

1. hospitalization for illness or injury ______ ☐ ☐
2. an allergic reaction to ______ ☐ ☐
   - ☐ aspirin, ibuprofen, acetaminophen, codeine
   - ☐ penicillin
   - ☐ erythromycin
   - ☐ tetracycline
   - ☐ sulfa
   - ☐ local anesthetic
   - ☐ fluoride
   - ☐ metals (nickel, gold, silver, ________)
   - ☐ latex
   - ☐ other ______
3. heart problems, or cardiac stent within the last six months ___ ☐ ☐
4. history of infective endocarditis ______ ☐ ☐
5. artificial heart valve, repaired heart defect (PFO) ______ ☐ ☐
6. pacemaker or implantable defibrillator ______ ☐ ☐
7. orthopedic implant (joint replacement) ______ ☐ ☐
8. rheumatic or scarlet fever ______ ☐ ☐
9. high or low blood pressure ______ ☐ ☐
10. a stroke (taking blood thinners) ______ ☐ ☐
11. anemia or other blood disorder ______ ☐ ☐
12. prolonged bleeding due to a slight cut (INR > 3.5) ______ ☐ ☐
13. emphysema, shortness of breath, sarcoidosis ______ ☐ ☐
14. tuberculosis, measles, chicken pox ______ ☐ ☐
15. asthma ______ ☐ ☐
16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus) ☐ ☐
17. kidney disease ______ ☐ ☐
18. liver disease ______ ☐ ☐
19. jaundice ______ ☐ ☐
20. thyroid, parathyroid disease, or calcium deficiency ______ ☐ ☐
21. hormone deficiency ______ ☐ ☐
22. high cholesterol or taking statin drugs ______ ☐ ☐
23. diabetes (HbA1c = ______) ______ ☐ ☐
24. stomach or duodenal ulcer ______ ☐ ☐
25. digestive disorders (i.e. celiac disease, gastric reflux) ______ ☐ ☐
26. osteoporosis/osteopenia (i.e. taking bisphosphonates) ___ ☐ ☐

YES NO

27. arthritis ______ ☐ ☐
28. autoimmune disease ______ ☐ ☐
    (i.e. rheumatoid arthritis, lupus, scleroderma)
29. glaucoma ______ ☐ ☐
30. contact lenses ______ ☐ ☐
31. head or neck injuries ______ ☐ ☐
32. epilepsy, convulsions (seizures) ______ ☐ ☐
33. neurologic disorders (ADD/ADHD, prion disease) ______ ☐ ☐
34. viral infections and cold sores ______ ☐ ☐
35. any lumps or swelling in the mouth ______ ☐ ☐
36. hives, skin rash, hay fever ______ ☐ ☐
37. STI / STD / HPV ______ ☐ ☐
38. hepatitis (type ___) ______ ☐ ☐
39. HIV / AIDS ______ ☐ ☐
40. tumor, abnormal growth ______ ☐ ☐
41. radiation therapy ______ ☐ ☐
42. chemotherapy, immunosuppressive medication ______ ☐ ☐
43. emotional difficulties ______ ☐ ☐
44. psychiatric treatment ______ ☐ ☐
45. antidepressant medication ______ ☐ ☐
46. alcohol / recreational drug use ______ ☐ ☐

ARE YOU:

47. presently being treated for any other illness ______ ☐ ☐
48. aware of a change in your health in the last 24 hours
    (i.e. fever, chills, new cough, or diarrhea) ______ ☐ ☐
49. taking medication for weight management ______ ☐ ☐
50. taking dietary supplements ______ ☐ ☐
51. often exhausted or fatigued ______ ☐ ☐
52. experiencing frequent headaches ______ ☐ ☐
53. a smoker, smoked previously or use smokeless tobacco _ ☐ ☐
54. considered a touchy / sensitive person ______ ☐ ☐
55. often unhappy or depressed ______ ☐ ☐
56. taking birth control pills ______ ☐ ☐
57. currently pregnant ______ ☐ ☐
58. prostate disorders ______ ☐ ☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

____

List all medications, supplements, and or vitamins taken within the last two years.

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature ______________________ Date ________

Doctor's Signature ______________________ Date ________

ASA ______ (1-6) ○ ○ ○

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DENTAL HISTORY

Name________________________ Nickname________________________ Age________
Referred by________________________ How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Previous Dentist ________________________ How long have you been a patient?__________ Months/Years
Date of most recent dental exam ____/____/____ Date of most recent x-rays ____/____/____
Date of most recent treatment (other than a cleaning) ____/____/____
I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? ________________________

PLEASE ANSWER YES OR NO TO THE FOLLOWING: YES NO

PERSONAL HISTORY

#	Question	YES	NO
1.	Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____]	☐	☐
2.	Have you had an unfavorable dental experience?	☐	☐
3.	Have you ever had complications from past dental treatment?	☐	☐
4.	Have you ever had trouble getting numb or had any reactions to local anesthetic?	☐	☐
5.	Did you ever have braces, orthodontic treatment or had your bite adjusted?	☐	☐
6.	Have you had any teeth removed or missing teeth that never developed?	☐	☐

GUM AND BONE

#	Question	YES	NO
7.	Do your gums bleed or are they painful when brushing or flossing?	☐	☐
8.	Have you ever been treated for gum disease or been told you have lost bone around your teeth?	☐	☐
9.	Have you ever noticed an unpleasant taste or odor in your mouth?	☐	☐
10.	Is there anyone with a history of periodontal disease in your family?	☐	☐
11.	Have you ever experienced gum recession?	☐	☐
12.	Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?	☐	☐
13.	Have you experienced a burning or painful sensation in your mouth not related to your teeth?	☐	☐

TOOTH STRUCTURE

#	Question	YES	NO
14.	Have you had any cavities within the past 3 years?	☐	☐
15.	Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?	☐	☐
16.	Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?	☐	☐
17.	Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth?	☐	☐
18.	Do you have grooves or notches on your teeth near the gum line?	☐	☐
19.	Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?	☐	☐
20.	Do you frequently get food caught between any teeth?	☐	☐

BITE AND JAW JOINT

#	Question	YES	NO
21.	Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	☐	☐
22.	Do you feel like your lower jaw is being pushed back when you bite your teeth together?	☐	☐
23.	Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?	☐	☐
24.	Have your teeth changed in the last 5 years, become shorter, thinner or worn?	☐	☐
25.	Are your teeth becoming more crooked, crowded, or overlapped?	☐	☐
26.	Are your teeth developing spaces or becoming more loose?	☐	☐
27.	Do you have more than one bite, squeeze, or shift your jaw to make your teeth fit together?	☐	☐
28.	Do you place your tongue between your teeth or close your teeth against your tongue?	☐	☐
29.	Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	☐	☐
30.	Do you clench your teeth in the daytime or make them sore?	☐	☐
31.	Do you have any problems with sleep (i.e. restlessness), wake up with a headache or an awareness of your teeth?	☐	☐
32.	Do you wear or have you ever worn a bite appliance?	☐	☐

SMILE CHARACTERISTICS

#	Question	YES	NO
33.	Is there anything about the appearance of your teeth that you would like to change?	☐	☐
34.	Have you ever whitened (bleached) your teeth?	☐	☐
35.	Have you felt uncomfortable or self conscious about the appearance of your teeth?	☐	☐
36.	Have you been disappointed with the appearance of previous dental work?	☐	☐

Patient's Signature ________________________ Date__________

Doctor's Signature ________________________ Date__________

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Financial Agreement

- I agree to pay for all treatment at the time of service, unlessother financial arrangements have been made.
- There will be a $25.00 charge for returned checks.
- We reserve the right to charge for missed appointments, in the event this happens we require a cedit card to reserve future appointments.
- Finance charges will be applied to all accounts over 60 days.
- All accounts over 90days past due will be turned over to a local collection agency. In addition to the balance, a 35%collection will fee will be added to cover the costs.

We accept Visa, MasterCard, Discover, Amex, and Care Credit

Insurance: Your co-pay is due at the time of treatment

I agree that it is my responsibility to understand benefits, deductibles, co-payments, and limitations. I further understand this office will bill my insurance as a courtesy to me, but I am responsible to pay any unpaid balance left by my insurance. I also understand that it is my responsibility to notify this office of any insurance changes.

I understand my dental insurance carrier may reduce payment for tooth-colored fillings on posteriorteeth and allow an alternate benefit of amalgam fillings. I agree thhedifference between the Dentist's fee for tooh-colored fillings, and the amount paid by my insurance is my responsibility.

All levels of payment by insurance companies, including allowed fees, usual and customary (UCR), are governed by the premiums paid. They have nothing to do with the consant dedication of supplying our patients with the highest quality of care. The treatment recommended by Desert Breeze Dental is never based on insurance company allowances-your treatment should not be governed by your insurance contract.

Consent for purposes of Treatment, Payment, nd Healthcare Operations

I consent to the use or disclosure of my protected health information by Desert Breeze Dentalfor the purpose of diagnosis or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations of Desert Breeze Dental. I understand that diagnosis or treatment of me by Desert Breeze Dental may be conditioned upon my consent as evidenced by my signature on this document. I understand I have the rightt o request a restriction as to how my protected health information is disclosed to carry out treatment, payment or healthcareoperations of the practice. Desert Breeze Dental is not required to agree to the restrictions that I may request. Howeverif they agree to ther estrictions I request, the restrictionsare binding. I have the right to revokethis consent, in writing at any time except to the extent that Desert Breeze Dental has taken action as received on this consent.

My "protectedhealth information" means health information, including demographic information, collected from me and created and received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition, and identifies me, or there is a reasonable basis to believe the may identify me.

Acknowledgement of receipt of notice of privacy practices

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 decided whether to sign this consent. Our notice provides a description of our treatment, payment activites, and healthcare operations, of the uses and disclosures we make of your protected healthcare information, and of other important mattersabout your protected health information. 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. Those changes may apply to any of you proteted health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice at any time, by contacting Troy at DesertBreeze Dental 2000@yahoo.com oor telephone (702)869-0032

Right to Revoke: you 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 the revocation of 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 continue treating you if you revoke this consent:

I have full opportunity to read and consider the contents of this consent 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.

Patient Signature:______________________________ Date:______________