

CAMPUS

FAMILY DENTAL

PATIENT REGISTRATION

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

Preferred Name: _____ Patient is: Policy Holder
 Responsible Party

Responsible Party (parent/guardian if minor)

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

Address: _____ Address 2: _____

City, State, Zip: _____ Home Phone: _____

Name of Employer: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc. Sec. _____ Driver Lic: _____

Responsible Party is also a Policy Holder for Patient

Patient Information

Address: _____ Address: _____

City: _____ State/Zip: _____ Home Phone: _____

Name of Employer: _____ 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.

Employment Status: Full Time Part Time Retired

Student Status: Full Time Part Time

Additional Comments:

Employer ID: _____

Pref. Dentist: _____

Carrier ID: _____

Pref. Pharmacy: _____

In order to maximize your insurance benefits to the fullest, please complete the following if card not provided:

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: () Self () Spouse () Child () Other
Insured Soc. Sec. _____ Insured Birth Date: _____
Employer: _____ Insurance Company: _____ Group #: _____
Address: _____ Address: _____
City, State, Zip: _____ City, State, Zip: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: () Self () Spouse () Child () Other
Insured Soc. Sec. _____ Insured Birth Date: _____
Employer: _____ Insurance Company: _____ Group #: _____
Address: _____ Address: _____
City, State, Zip: _____ City, State, Zip: _____

Emergency Contact

Name: _____ Home/Cell Phone: _____
Relationship: _____ Work Phone: _____

How did you hear about our office?

- () www.purezendentistry.com () Google () Yelp () Facebook () ZocDoc () Amazon Local () Living Social
- () Doctor's Office: _____ () Provider: _____ () Friend/Relative: _____
- () Other Source: _____ () Not Referred

DENTAL HISTORY

Date of Last Dental Visit: _____
1. How often you brush your teeth? _____
2. Do your gums bleed while brushing or flossing? () Yes () No
3. Are you currently experiencing any pain? () Yes () No
4. Are your teeth sensitive to hot or cold? () Yes () No
5. Are your teeth sensitive to sweet or sour? () Yes () No
6. Do you wear dentures or partials? () Yes () No
7. How would you rate your smile? () 1 () 2 () 3 () 4 () 5 () 6 () 7 () 8 () 9 () 10
8. Is anything you want to change about your smile? () Yes () No If yes, please explain: _____

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is 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.

Physician Name: _____ Office Phone Number: (_____) _____

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

Women: Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other: Please explain: _____

Are you taking any of blood thinner medications?

If yes, please explain: _____

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

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Renal Disease |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Herpes | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Easily Winded | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Irregular Heartbea | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting Spell/Dizziness | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Swelling of Limbs |
| <input type="checkbox"/> Bone Density problems | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Osteoporpsis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Osteopunia | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Pain in Jaw Joint | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Parathyroid Disease | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Heart Pace Maker | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Yellow Jaundice |
| <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Radiation Treatments | |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Recent Weight Loss | |

Have you ever had any serious illness not listed above? Yes No

If yes, please explain: _____

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 (Legal Guardian, if Minor)

Date

Doctor's Signature

Date

NOTICE OF PRIVACY ACTS

THIS TREATMENT DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This practice is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment

We may disclose your health care information to other health care professionals within our practice for the purpose of treatment, payment or health care operations.

Payment

We may disclose your health care information to your insurance provider for the purpose of payment or health care operations.

Worker's Compensation

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care, about your medical condition or in the event of an emergency or of your death.

Public Health

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings

We may disclose your health information in the course of any administrative or judicial proceedings.

Law Enforcement

We may disclose your health information to a law enforcement official for the purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons

We may disclose your health information to coroners or medical examiners.

Organ Donation

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies

We may disclose your health information for military, national security, prisoner and government benefits and purposes.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that this practice is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method of communication or delivery, upon your request.
- You have the right to inspect and request a copy of your health information.
- You have a right to request that this practice amend your protected health information. Please be advised, however, that this practice is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by this practice.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

This practice reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, this practice is required by law to comply with this Notice.

This practice is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice, or if you want more information about your privacy rights, please contact our Privacy Officer by calling this office.

Complaints

Complaints about your privacy rights, or how this practice has handled your health information should be directed to our Privacy Officer by calling this office.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights 200
Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of ____/____/____.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this Acknowledgement

I have had full opportunity to read, understand the contents, and I have received a copy of this office's Notice of Privacy Practices. I understand that by signing this form, I am giving my consent for use and disclosure of my protected health information to carry out all payment activities and health care operations.

Patient's name _____ Date _____

Signature _____
(Parent/Guardian if minor)

AUTHORIZATION FOR COMMUNICATION

I authorize Campus Family Dental to release the following information about my health care (please check all that apply):

- Any and all information
- Information necessary to schedule, confirm, cancel, or reschedule appointments
- Information about prescriptions
- Information about my bills or account
- I grant permission to this individual to bring my child to his/her appointments

This authorization applies to the following individual(s)

Name: _____ Relationship to the Patient: _____

- I choose not to authorize any individuals at this time

I understand that this authorization is valid until revoked by the patient, or the patient's parent/guardian.