Patient Registration Form

Patient Information

First Name	MI	Last Name	Date of Birth	Gender	Social Security #	Marital Status

Address	City	State	Zip Code

Phone Numbers	Email Address	Parent/Guarantor Name

Insurance & Financial Information

Primary Dental Insurance	Subscriber ID Number	Group Number

Policy Holders Name	Policy Holders Date of Birth	Employer Name

Secondary Dental Insurance	Subscriber ID Number	Group Number

Policy Holders Name	Policy Holders Date of Birth	Employer Name

Person Responsible For the Account	Address (If Different From Above)

Emergency Contact Information

Emergency Contact Name	Relationship to Patient	Phone Number

Emergency Contact Name	Relationship to Patient	Phone Number

*The information I have provided on this form is correct to the best of my knowledge. I authorize the administration of any medications and the performance of any procedures that are necessary for my dental care. I understand and agree that decisions for dental treatment are between the Doctor and myself, and recommendations for my dental health are not dictated by my insurance coverage.

*I authorize Family & Cosmetic Gentle Dentistry, LTD to submit insurance claims on my behalf. I understand that I am financially responsible for all dental care provided and that regardless of any estimate provided to me, any balance owed after my claim is processed is my responsibility and is due upon receipt of a statement.

*I understand that if I need to cancel or reschedule an appointment, a 48-hour notice is required. If I am unable to give this notice, I am aware that I may no longer be able to schedule a reserved appointment time at any location and/or I may be charged a $45.00 cancellation fee by Family & Cosmetic Gentle Dentistry, LTD.

Signature: _____ **Date:**_____

(Patient\guardian or personal representative)

If this consent is signed by a guardian or personal representative on behalf of the patient, complete the following:

Name: _____ **Relationship to the Patient:** _____

Gentle DENTISTRY

Patient Health History Form

PATIENT NAME: **DOB:**

Dental History

1. Previous Dentist:_____ Last dental exam: _____
2. Are you satisfied with your past dental treatment? ☐ **Yes**
3. Do you have any dental fear or anxiety? ☐ **Yes**
4. Are your teeth sensitive to: ☐ ***Hot*** ☐ ***Cold*** ☐ ***Pressure*** ☐ ***Chewing*** ☐ ***Sweets*** ***Other*** _____
5. Do you have any signs of gum disease such as bleeding, odors, or pain to the gum tissue? ☐ **Yes**
6. Do you have any pain or clicking/noise in your jaw joints? ☐ **Yes** – Where? _____
7. Any swelling or lumps in your mouth? ☐ **Yes** – Where? _____
8. If you could change your teeth, what would you change? _____
   Straighter? ☐ **Yes** *Whiter?* ☐ **Yes** *Tooth Colored Fillings?* ☐ **Yes**
9. What prompted you to seek dental treatment at this time? _____

Medical History

1. Name of physician: _____Date of last physical: _____
2. Phone number and address/location of medical facility: _____
3. Have you traveled outside the United States within the last month? ☐ **Yes** Where? _____
4. Are you presently under the care of a physician or in the last 5 years? ☐ **Yes**
5. Have you been hospitalized or had surgery in the last 5 years? ☐ **Yes**
6. Are you allergic to/have adverse effects to: ☐ ***Penicillin*** ☐ ***Codeine*** ☐ ***Local Anesthetic*** ☐ ***Nickel*** ☐ ***Mercury***
   ☐ ***Latex*** ☐ ***Bisphosphonate*** ***Other*** _____ ☐ **NONE**
7. Have you ever had complications from a prior surgery, sedation, or anesthesia? ☐ **Yes**
8. Do you smoke or use smokeless tobacco? ☐ **Yes** If so, how much per day? _____
9. Do you use or have a history of using recreational drugs? ☐ **Yes** If so, what? _____
10. Do you have any sort of breathing difficulty, snore, or have sleep apnea? **Yes**
11. WOMEN ONLY – Are you pregnant or nursing? ☐ **Yes** _____
12. Do you have, or have you ever been diagnosed with any of the following?

Please Check if yes

- ☐ - High Blood Pressure
- ☐ - Heart Murmur
- ☐ - Rheumatic Fever
- ☐ - Mental Health Issues
- ☐ - AIDS/HIV Positive
- ☐ - Tumors/Cancer
- ☐ - Asthma or Hay Fever
- ☐ - TB or Lung Disorders
- ☐ - Diabetes A1C ____
- ☐ - Thyroid Problems
- ☐ - Ulcers
- ☐ - *Mitral Valve Prolapse*
- ☐ - *Heart Disease/Heart Attack*
- ☐ - *Blood Transfusion*
- ☐ - *Chemical Dependency*
- ☐ - *Epilepsy/Seizures*
- ☐ - *Radiation Therapy*
- ☐ - *Auto Immune Disease*
- ☐ - *COPD/Chronic Cough*
- ☐ - *Liver Problems*
- ☐ - *Kidney Problems*
- ☐ - *Joint Replacement/Pins/Rods/Scews*
- ☐ - *Congenital Heart Disease*
- ☐ - *Circulatory Problems*
- ☐ - *Stroke – Year ____*
- ☐ - *Chest Pain/Heart*
- ☐ - *Palpitations*
- ☐ - *Fainting Spells*
- ☐ - *Arthritis*
- ☐ - *Tonsillitis/Sinus Trouble*
- ☐ - *Pneumonia*
- ☐ - *Hepatitis – Type _____*
- ☐ - *Jaundice*

Please list all other conditions/healtScrh prewos blems that you have or may be concerned about that are not listed

_____

13. List all medications that you are taking. Include over the counter medications, vitamins, and supplements.

_____

Patient Signature: _____**Date:**_____

(Patient\guardian or personal representative

FOR OFFICE USE ONLY - DDS reviewed original medical history: _____ Date_____

Patient Health History Form

SECTION A: PATIENT GIVING CONSENT

Legal Name: **DOB**:

Address: **Telephone:**

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENT CAREFULLY

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 operation.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices and Minnesota access to health records before you decide to whether to sign this Consent. They provide a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of both accompanies this Consent. We encourage you to read them carefully and completely before signing this consent.

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, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices and Minnesota access to health records, including any revisions of our Notice, at any time by contacting:

Systems and Compliance Manager - Rosalind Davis - (952) 224-9779 - SCM@smilemn.com - 4100 Shoreline Dr #4 Spring Park, MN 55384*

Right to Revoke: You will 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 or sign and date this form. Please understand that revocation of this Consent will not affect any action took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Signature and Acknowledgement of Receipt of Notice of Privacy Practices

I have had full opportunity to read and consider the contents of the Consent for use and disclosure of health records, your Notice of Privacy Practices and Minnesota access to health records. . I understand by signing this Consent form, I am giving my consent to Family and Cosmetic Gentle Dentistry, Ltd. and their Business associates to use and disclosure my protected health information to carry out treatment, payment activities and health care operations. I have received and reviewed a copy of Family & Cosmetic Gentle Dentistry, Ltd Notice of Privacy Policy and Minnesota Access to Health Records Notice of rights. I understand that I if I have any questions, I should ask the privacy official of the practice.

Name:

Signature: _____**Date:**_____

(Patient\guardian or personal representative)

If this consent is signed by a guardian or personal representative on behalf of the patient, complete the following:

Name: _____ **Relationship to the Patient:** _____

SECTION C: AUTHORIZATION TO DISCUSS PROTECTED HEALTH INFORMATION:

To help with my care or billing, my care team at Family and Cosmetic Gentle Dentistry may share my protected health information with the following individual(s) and/or leave a voice mail regarding my dental care at the following number(s)

Name: _____ **Phone:** _____ **Relationship to me:** _____

Name: _____ **Phone:** _____ **Relationship to me:** _____

Authorized information to be shared with person(s) listed above: ***If no one listed above, please check Nothing***

All ____ Scheduling ____ Billing ____ Dental Treatment ____Health Conditions ____ Nothing ____

* This consent applies to Family and Cosmetic Gentle Dentistry shared electronic dental records
* My care team will release all details to the person(s) named above
* This form does not have an end date. If I want to change, add or remove information on this form, I will fill out a new form
* Once my information is shared with the person(s) named above, it is no longer protected by privacy laws (Family and Cosmetic Gentle Dentistry cannot prevent these persons from sharing my information with a third party)

Name:

Signature: _____**Date:**_____

(Patient\guardian or personal representative)

If this consent is signed by a guardian or personal representative on behalf of the patient, complete the following:

Name: _____ **Relationship to the Patient:** _____

FOR OFFICE USE ONLY - We attempted to obtain written acknowledgment of receipt of our Privacy Practices, but it could not be obtained because:

_____ Individual refused to sign _____Communication barriers prohibited obtaining the acknowledgment _____An emergency situation

_____Other (Please Specify) _____