



# Patient Registration

## Patient Information

Patient Name \_\_\_\_\_ Legal Name \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 Email Address \_\_\_\_\_ Patient DOB \_\_\_\_\_ Sex:  M  F  
 Marital Status:  Single  Married  Divorced  Widowed Social Security # \_\_\_\_\_  
 Full-time student If yes, where? \_\_\_\_\_ Responsible Party:  Self  Other \_\_\_\_\_

Patient's Employer \_\_\_\_\_ Driver License# \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Spouse's Name \_\_\_\_\_ Spouse's Cell \_\_\_\_\_

**IN CASE OF EMERGENCY, CONTACT**  
 Name \_\_\_\_\_ Relationship \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

**What brings you in today?** \_\_\_\_\_  
 \_\_\_\_\_  
**How did you hear about our practice?** \_\_\_\_\_  
 \_\_\_\_\_

## Dental Insurance

**Primary** Insurance Company \_\_\_\_\_ Subscriber Name \_\_\_\_\_  
 Relationship to Insured:  Self  Spouse  Child  Other \_\_\_\_\_  
 ID# \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber's DOB \_\_\_\_\_  
 Subscriber's Employer \_\_\_\_\_  
**Secondary** Insurance Company \_\_\_\_\_ Subscriber Name \_\_\_\_\_  
 Relationship to Insured:  Self  Spouse  Child  Other \_\_\_\_\_  
 ID# \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber's DOB \_\_\_\_\_  
 Subscriber's Employer \_\_\_\_\_

### Assignment and Release

I certify that I and/or my dependent(s) have insurance coverage with \_\_\_\_\_ (Insurance Company) and assign directly to Dr. \_\_\_\_\_ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my healthcare information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

\_\_\_\_\_  
**Signature** of Patient, Parent or Guardian **Date** \_\_\_\_\_  
 \_\_\_\_\_  
**Please Print Name** of Patient, Parent or Guardian **Relationship** to Patient \_\_\_\_\_

# Health History

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

- Are you under a physician's care now?  Yes  No If yes \_\_\_\_\_
- Have you ever been hospitalized or had a major operation?  Yes  No If yes \_\_\_\_\_
- Have you ever had a serious head or neck injury?  Yes  No If yes \_\_\_\_\_
- Are you taking any medications, pills or drugs?  Yes  No If yes \_\_\_\_\_
- Do you take, or have you taken, Phen-Fen or Redux?  Yes  No If yes \_\_\_\_\_
- Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?  Yes  No If yes \_\_\_\_\_
- Are you on a special diet?  Yes  No If yes \_\_\_\_\_
- Do you use tobacco?  Yes  No If yes \_\_\_\_\_

I am a woman who is...  Pregnant/Trying to get pregnant  Nursing  Taking oral contraceptives  N/A

Are you allergic to any of the following?

- Aspirin  Penicillin  Codeine  Acrylic  Other \_\_\_\_\_
- Metal  Latex  Sulfa Drugs  Local Anesthetics  No Known Allergies

Do you use controlled substances?  Yes  No If yes \_\_\_\_\_

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

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> AIDS/HIV Positive         | <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> Hepatitis B or C      | <input type="checkbox"/> Rheumatic Fever            |
| <input type="checkbox"/> Alzheimer's Disease       | <input type="checkbox"/> Drug Addiction            | <input type="checkbox"/> Herpes                | <input type="checkbox"/> Rheumatism                 |
| <input type="checkbox"/> Anaphylaxis               | <input type="checkbox"/> Easily Winded             | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Scarlet Fever              |
| <input type="checkbox"/> Anemia                    | <input type="checkbox"/> Emphysema                 | <input type="checkbox"/> High Cholesterol      | <input type="checkbox"/> Shingles                   |
| <input type="checkbox"/> Angina                    | <input type="checkbox"/> Epilepsy or Seizures      | <input type="checkbox"/> Hives or Rash         | <input type="checkbox"/> Sickle Cell Disease        |
| <input type="checkbox"/> Arthritis/Gout            | <input type="checkbox"/> Excessive Bleeding        | <input type="checkbox"/> Hypoglycemia          | <input type="checkbox"/> Sinus Trouble              |
| <input type="checkbox"/> Artificial Heart Valve    | <input type="checkbox"/> Excessive Thirst          | <input type="checkbox"/> Irregular Heartbeat   | <input type="checkbox"/> Spina Bifida               |
| <input type="checkbox"/> Artificial Joint          | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> Kidney Problems       | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Asthma                    | <input type="checkbox"/> Frequent Cough            | <input type="checkbox"/> Leukemia              | <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> Blood Disease             | <input type="checkbox"/> Frequent Diarrhea         | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Swelling of Limbs          |
| <input type="checkbox"/> Blood Transfusion         | <input type="checkbox"/> Frequent Headaches        | <input type="checkbox"/> Low Blood Pressure    | <input type="checkbox"/> Thyroid Disease            |
| <input type="checkbox"/> Breathing Problems        | <input type="checkbox"/> Genital Herpes            | <input type="checkbox"/> Lung Disease          | <input type="checkbox"/> Tonsillitis                |
| <input type="checkbox"/> Bruise Easily             | <input type="checkbox"/> Glaucoma                  | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tuberculosis               |
| <input type="checkbox"/> Cancer                    | <input type="checkbox"/> Hay Fever                 | <input type="checkbox"/> Osteoporosis          | <input type="checkbox"/> Tumors or Growths          |
| <input type="checkbox"/> Chemotherapy              | <input type="checkbox"/> Heart Attack/Failure      | <input type="checkbox"/> Pain in Jaw Joints    | <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 Pacemaker           | <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    |   |
| <input type="checkbox"/> Cortisone Medicine        | <input type="checkbox"/> Hepatitis A               | <input type="checkbox"/> Renal Dialysis        |   |

Have you ever had any serious illness not listed above?  Yes  No If yes \_\_\_\_\_

Comments \_\_\_\_\_

To the best of my knowledge, the questions on this form have been answered accurately. 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.

\_\_\_\_\_  
Please Print Name of Patient, Parent or Guardian

\_\_\_\_\_  
Signature of Patient, Parent or Guardian

\_\_\_\_\_  
Date



# Office Policy

We are dedicated to providing you with the very best dental care and service, as a result, your understanding of our office policy is an essential element of your care and treatment. If you have any questions, please feel free to discuss them with our office staff.

## Appointments

Initials

Our policy allows us to schedule appointments for our patients, with respect for your time, the next patient's time, and the doctor and hygienist's time. If a change needs to be made to your appointment, we ask you to call with 48 hours notice in order to reschedule another appointment in advance. We also request that you be on time for your visits. If you are more than 10 minutes late, you may have to reschedule your appointment.

## Group or Individual Dental Insurance

Initials

**Treatment recommendations are based on your health not on your insurance or lack thereof. If you have dental insurance it is your responsibility to KNOW YOUR BENEFITS AND LIMITATIONS and to provide us with complete and accurate information to file your claims.** Your insurance is an agreement between you and your insurance company, not between your insurance company and our office. We cannot be certain of what your insurance covers. The amount they pay varies from one policy to another. As a courtesy to you, our office will call to verify benefits; however, the benefits quoted to us by your insurance company are not a guarantee of payment. **It is to be understood and agreed that any services rendered are charges to you directly and you are personally responsible for payment of any non-covered services, downgrades, deductibles, or co-payments.** As a convenience to you, we will file your insurance, and you will be billed for any balance that remains after insurance has paid. If we have not received payment on a claim after 60 days, the entire balance of that claim is due immediately from the patient. If your insurance company later pays, we will refund your payment.

Secondary insurance claims will be filed as a courtesy. Benefits will not be verified. The portion owed for each visit will reflect the primary insurance only. Additional discounts are not applicable for in-network insurance plans and coupons.

## Financial

Initials

**Payment is due when services are rendered.** For your convenience, we accept cash, checks and credit cards. **For major procedures we collect 50% of your estimated patient portion to reserve an appointment time with Dr. Cummings, then the remaining balance when services are rendered.** Payment plan options are available through CareCredit and LendingClub. Any account over 90 days old will be assessed a finance charge of 1.5% of the unpaid balance. **You, the patient, agree to pay for reasonable attorney's fees, court costs, and costs of collection on overdue accounts. There will also be a \$35 charge for any returned check.**

I have read and understand Advanced Dental Health Center's Office Policy and I agree to be bound by its terms. I am aware that I will be charged for missed appointments, and I agree to these terms.

\_\_\_\_\_  
Signature of Patient, Parent or Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please Print Name of Patient, Parent or Guardian

\_\_\_\_\_  
Staff signature



# Acknowledgment of Privacy Practices

I, \_\_\_\_\_, have reviewed and/or received a copy of this office's Notice of Privacy Practices  
*(please print name)*

\_\_\_\_\_  
**Signature** of Patient, Parent or Guardian

\_\_\_\_\_  
**Date**

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**OFFICE USE ONLY BELOW THIS LINE**

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We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices,  
but acknowledgement could not be obtained for the following reason:

- Communication Barrier
- Other (Please Specify)



# Authorization for Disclosure of My Healthcare Information

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

*(please print)*

## Advanced Dental Health Center may disclose the following healthcare information:

*(check all that apply)*

- All healthcare information in my dental record (X-Rays, bills, etc.)
- Healthcare information in my dental record relating to the following treatment or condition:

\_\_\_\_\_

Date of Service \_\_\_\_\_

## Advanced Dental Health Center may disclose this healthcare information to the following individual(s):

*(spouse, family member, etc.)*

Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

**I DO NOT wish to have my healthcare information disclosed to anyone.**

\_\_\_\_\_  
**Signature** of Patient, Parent or Guardian

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Please Print Name** of Patient, Parent or Guardian

\_\_\_\_\_  
**Relationship** to Patient