PATIENT REGISTRATION FORM

2015 Herr Lane, Ste. D
Louisville, KY 40222
502-509-1980

TODAY'S DATE:	

PATIENT INFORMATION

GENDER:	FEMALE		MALE		FAMILY STATUS:	SINGLE		MARRIED		DIVORCED		CHILD		OTHER	

FIRST NAME:	MI.	LAST NAME:	D.O.B	SOCIAL SECURITY #

STREET ADDRESS:	CITY:	STATE:	ZIP:

HOME PHONE:	CELL PHONE:	WORK:	EMAIL ADDRESS:

PATIENT EMPLOYER/SCHOOL:		OCCUPATION/MAJOR:	
WHOM MAY WE THANK FOR REFERRING YOU?			
IN CASE OF EMERGENCY WHO SHOULD BE NOTIFIED?	NAME:		PHONE:
PERSON RESPONSIBLE FOR THE ACCOUNT:		RELATION TO PATIENT:	

PRIMARY INSURANCE

POLICYHOLDER FIRST NAME:	MI.	LAST NAME:	D.O.B	SOCIAL SECURITY #

STREET ADDRESS: **if different than above*	CITY:	STATE:	ZIP:

DENTAL INSURANCE COMPANY:		SUBSCRIBERS EMPLOYER:	
INSURANCE CO. ADDRESS:		INSURANCE CO. PHONE #:	
GROUP OR POLICY #:		SUBSCRIBER ID#	

SECONDARY INSURANCE

POLICYHOLDER FIRST NAME:	MI.	LAST NAME:	D.O.B	SOCIAL SECURITY #

STREET ADDRESS: **if different than above*	CITY:	STATE:	ZIP:

DENTAL INSURANCE COMPANY:		SUBSCRIBERS EMPLOYER:	
INSURANCE CO. ADDRESS:		INSURANCE CO. PHONE #:	
GROUP OR POLICY #:		SUBSCRIBER ID#	

General Treatment & HIPAA Consent

I give my consent that I, (or my above named dependent) receive dental treatment, education, and other dental related services. I authorize the administration of anesthetics, as may be considered necessary, and to the use of oral x-rays during the treatment. I will receive instructions about the benefits and risks of the necessary procedures, and I will have the opportunity to discuss and approve the recommended treatment. I acknowledge that I have not received guarantees, warranties, or representations concerning the results of the treatment or procedures. I accept the responsibility of the following (or helping my above named dependent follow) oral hygiene and post-op instructions, come to all the appointments on the proper day and time, provide accurate and updated health information, and alert this office of anything that may adversely affect the treatment. By consenting to treatment, I understand there is a risk of infectious diseases. Despite taking reasonable precautions to ensure your health and safety. It is impossible to eliminate all risk of contracting an infectious disease with receiving dental care. I have the right to withdraw this consent at any time. I will still be responsible for the unpaid balance and for any complication arising from the treatment interruption.

Our dental practice keeps information of all your dental visits. We are required by law to maintain the privacy of your protected health information and provide you with notice of our legal duties and privacy practices with your information upon request. Law requires us, and by our code of ethics, to keep your information private and follow the practices outlined in this notice. I have had full opportunity to read and consider the contents of this notice of privacy practices. I understand I am giving my permission to use and disclose my protected health information to use in treatment, payment activities, and healthcare operations. I also understand that I have the right to revoke or modify this permission.

AUTHORIZING & RESPONSIBLE PERSON:		DATE:	

Financial Agreement

Thank you for allowing us the opportunity to care for your dental needs. We are excited to partner with you to improve and maintain your oral health. For your convenience you can pay for your dental treatment with cash, credit card, check or through a third party financer who partners with us, to ensure all patients receive the care they need. We will collect the payment of your treatment at the time of service. If you would like to use your dental insurance, we will gladly file the insurance claims on your behalf for the portion you expect your insurance to pay. We will also post to your account any insurance payment and adjustments we may receive. We will let you know if your insurance covers only part of the claim, so that you may send us the payment for the balance. If for any reason, you have the need to change any financial arrangements, please let us know so that we may work with you. In the event, any portion of your balance remains unpaid longer than 30 days we will initiate a collection process, which may include collections and financing fees. By signing I agree to the steps of this agreement and understand personal information may be shared for collection purposes.

AUTHORIZING & RESPONSIBLE PERSON:		DATE:	

PATIENT REGISTRATION FORM

DENTAL HISTORY			
1.	Are you interested in orthodontic treatment (straightening of teeth)?	YES	NO
2.	Are you concerned about the whiteness of your teeth?	YES	NO
3.	Are you currently experiencing any discomfort or pain?	YES	NO
4.	Do your gums bleed while brushing or flossing?	YES	NO
5.	Do you grind or clench your teeth?	YES	NO
6.	Are you experiencing bad breath?	YES	NO
7.	Are you experiencing sensitivity to hot, cold and or sweets?	YES	NO
8.	Do you have or had sores in or around your mouth?	YES	NO
9.	Do you experience clicking or popping of the jaw?	YES	NO
10.	Do you have issues with food collecting between your teeth?	YES	NO
11.	How often do you brush your teeth?		
12.	How often do you floss your teeth?		
13.	In months, when was your last exam and cleaning	Last "full set" of x-rays (approx. 12-18 x-rays)	

NAME PREVIOUS DENTIST:		PHONE NUMBER	

MEDICAL HISTORY			
1.	Have you ever used a bisphosphonate medication such as: Fosamax, Actonel, Atelvia, Didronel, Boniva	YES	NO
2.	Have you ever taken any group of drugs collectively referred to as "fen-phen?" Such as Ionimin, Adipex, Fastin (phentermine), Pondimin (fenfluramine), and Redux (dexfenfluramine).	YES	NO

3.	Have you had any serious illness or operation?	YES		NO		*If yes, describe*					
4.	Have you ever had a blood transfusion?	YES		NO		*approx. date*					
5.	(**WOMEN**) Are you pregnant?	YES	NO	Are you nursing?		YES	NO	Taking birth control?		YES	NO
6.	Do you smoke or are you an ex-smoker?	YES	NO	# OF YRS. SMOKING?				# OF YRS SINCE QUITTING			

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING? *(check appropriate box)*

Aspirin		Codeine		Iodine		Latex		Penicillin		Sulfa		Local Anesthetic		Barbiturates		Other	

If you checked **other**, please specify the **allergy**:

Please list any medication/s that you are taking and the daily dosage: (use back if needed:)

NAME OF PHYSICIAN:		PHONE NUMBER	

MARK "YES" OR "NO" TO INDICATE IF YOU HAVE OR HAD ANY OF THE FOLLOWING:

AID/HIV	YES	NO	EPILEPSY	YES	NO	RESPIRATORY DISEASE	YES	NO
ANEMIA	YES	NO	FAINTING/DIZZINESS	YES	NO	RHEUMATIC FEVER	YES	NO
ARTHRITIS	YES	NO	GLAUCOMA	YES	NO	SCARLET FEVER	YES	NO
ARTIFICIAL HEART VALVE	YES	NO	HEADACHES	YES	NO	SHORTNESS OF BREATH	YES	NO
ARTIFICIAL JOINT	YES	NO	HEART PROBLEMS	YES	NO	SINUS TROUBLE	YES	NO
ASTHMA	YES	NO	HEPATITIS **TYPE?**	YES	NO	SKIN RASH	YES	NO
BACK PROBLEMS	YES	NO	HIGH BLOOD PRESSURE	YES	NO	SPECIAL DIET	YES	NO
BLEEDING ABNORMALLY, EXTRACTION/SURGERY	YES	NO	HERPES	YES	NO	STROKE	YES	NO
BLOOD DISORDER	YES	NO	JAUNDICE	YES	NO	SWOLLEN FEET OR ANKLES	YES	NO
CANCER	YES	NO	JAW PAIN	YES	NO	THYROID PROBLEMS	YES	NO
CHEMICAL DEPENDENCY	YES	NO	KIDNEY DISEASE	YES	NO	TONSILLITIS	YES	NO
CHEMOTHERAPY	YES	NO	LIVER DISEASE	YES	NO	TUBERCULOSIS	YES	NO
CIRCULATORY PROBLEMS	YES	NO	LOW BLOOD PRESSURE	YES	NO	TUMOR OR GROWTH	YES	NO
CONGENITAL HEART DISEASE	YES	NO	MITRAL VALVE PROLAPSE	YES	NO	ULCER	YES	NO
CORTISONE TREATMENT	YES	NO	NERVOUS PROBLEMS	YES	NO	VENEREAL DISEASE	YES	NO
COUGH, PERSISTENT OR BLOODY	YES	NO	PACEMAKER	YES	NO	WEIGHT LOSS, UNEXPLAINED	YES	NO
DIABETES	YES	NO	PSYCHIATRIC CARE	YES	NO			
EMPHYSEMA	YES	NO	RADIATION TREATMENT	YES	NO			

PLEASE PROVIDE ANY OTHER IMPORTANT MEDICAL INFORMATION HERE:

Thank You
&
WELCOME TO HEDGES DENTAL!