PATIENT REGISTRATION

PATIENT INFORMATION

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

Patient Is Also: ○ Policy Holder ○ Responsible Party Preferred Name: _____

Address: _____ Apt Number: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Sex: ○ Male ○ Female Marital Status: ○ Married ○ Single ○ Divorced ○ Widowed

Birth Date: _____ Social Security #: _____ Drivers License #: _____

Email Address: _____

How did you hear about us? _____

Emergency Contact: _____ Emergency Contact #: _____

RESPONSIBLE PARTY (IF SOMEONE OTHER THAN THE PATIENT)

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

Address: _____ Apt Number: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birth Date: _____ Social Security #: _____ Drivers License #: _____

IS RESPONSIBLE PARTY ALSO A POLICY HOLDER FOR PATIENT? ○ YES ○ NO

PRIMARY INSURANCE INFORMATION

Name of Policy Holder: _____

Policy Holder Social Security #: _____ Policy Holder Date of Birth: _____

PATIENT'S RELATIONSHIP TO POLICY HOLDER: ○ SELF ○ SPOUSE ○ CHILD ○ OTHER

Employer: _____

Insurance Company: _____

Insurance Claims Address: _____

City: _____ State: _____ Zip Code: _____

Insurance Member ID: _____ Group #: _____

SECONDARY INSURANCE INFORMATION

Name of Policy Holder: _____

Policy Holder Social Security #: _____ Policy Holder Date of Birth: _____

PATIENT'S RELATIONSHIP TO INSURED: ○ SELF ○ SPOUSE ○ CHILD ○ OTHER

Employer: _____

Insurance Company: _____

Insurance Address: _____

City: _____ State: _____ Zip Code: _____

Insurance Member ID: _____ Group #: _____

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

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, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____

Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: _____

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

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

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

Comments: _____

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, PARENT, or GUARDIAN _____ DATE _____

Dental History

Your goal for today: _____

When was your last dental cleaning? _____ Year(s)/Months ago

Your previous dental experiences were: Excellent Great Okay Bad

If you had a bad experience, please explain:

_____

Do you currently have dental pain? Yes No

Smile Analysis

Would you like to change anything about the appearance of your teeth or smile? Yes No

Are you self-conscious about your teeth or smile? Yes No

Do you have prior dental work that appears unnatural? Yes No

I am interested in the following

___ Exam/X-rays/cleaning ___ Crown(s) ___ Invisalign

___ Deep Cleaning ___ Implant(s) ___ Veneers

___ Filling(s) ___ Whitening ___ Dentures/Partials

___Cosmetic consultation

How did you hear about our office?

___ Google ___ Postcard ___ Website

___ Insurance ___ Facebook ___ Our sign

___Patient Referral; Who may we thank? _____

AUTHORIZATION TO RELEASE INFORMATION TO FAMILY MEMBER

Many of our patients allow family members such as their spouse, parents, or others to call and discuss dental treatment, medical, insurance, or billing information. Under the requirements of HIPAA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your dental treatment, medical, insurance, or billing information released to family members, you must sign this form. Signing this form will only give consent to release this information to the family members listed below. This consent form will not allow Curtis Family Dentistry to release any other information to these family members.

You have the right to revoke this consent in writing.

I authorize/allow Curtis Family Dentistry to release my dental treatment or billing information to the following person(s):

1. _____ Relationship to Patient _____
2. _____ Relationship to Patient _____
3. _____ Relationship to Patient _____

AUTHORIZATION TO LEAVE MESSAGE WITH HOUSEHOLD MEMBERS, ON VOICE MAIL, ON CELL PHONE:

Occasionally it is necessary for the staff of Curtis Family Dentistry to leave messages for patients. The purpose of these messages is to notify the patient that the dental staff would like to discuss or schedule your treatment or to ask a patient to call regarding an issue or concern. The purpose of this consent is to leave a message with members of your household, on your voice mail, or your cell phone.

**This practice performs automated call, email, and text appointment reminders. The signature below also provides your consent for such reminders.

You have the right to revoke this consent in writing.

Patient Name (Print): _____

Patient Signature: _____

Scheduling Policy

We realize time is a valuable commodity, not only for us but our patients as well. As you may know, we take pride in the fact that time is reserved specifically for one patient only. This is a decision we made to ensure exceptional care and service for our patients. We try to help remind patients with cards mailed the month prior to scheduled appointment and a telephone call two days prior to the appointment. Therefore, a missed or broken appointment causes a problem for other patients who want to schedule an appointment.

The following is an overview of our missed/cancelled appointment guidelines:

- Please schedule an appointment for a time you are confident you can make.
- A minimum of 24 business hours is required to cancel or reschedule an appointment.
- Please understand that in the future, there may be a charge for a missed appointment or an appointment cancelled with less than 24 hours' notice.

We understand that certain emergencies can and do arise, however, we thank you for your consideration and understanding.

I acknowledge and understand the above policy:

_____ _____

Name of Patient, Parent or Guardian Date

Curtis Family Dentistry
520 East Center Ave.
Mooresville, NC 28115

NOTICE OF PRIVACY PRACTICES

Curtis Family Dentistry understands that your medical and dental information is personal and we are committed to protecting it. We create a record of the care and services you receive at our office. We need this record to provide you with quality dental care and to comply with certain legal requirements. This notice will tell you about the way we may use and share your Protected Health Information (PHI) We have a Legal Duty to:

Keep your personal health information private and to

1. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information
2. Follow the terms of the current notice
3. Notify you in a timely manner of an accidental disclosure of your private health information

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices: When we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

USE AND DISCLOSURE OF YOUR PRIVATE HEALTH INFORMATION

The following describes different ways that we use and disclose your private health information. Not every use or disclosure is listed. However, we have listed all the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical or dental information for any purpose not listed below with-out your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

1. **For Treatment:** We may use your PHI to provide you with dental treatment or services. We may disclose medical information about you to healthcare providers who may be involved in your treatment both directly and indirectly.
2. **For Payment:** We may use and disclose your PHI for payment purposes. A bill may be sent to you, a third-party payer or to a collection agency. The information on or accompanying the bill may include your treatment information.
3. We will not sell or use your personal health information for marketing or fundraising purposes without first obtaining your signed authorization.
4. We are required to inform you if there are any financial conflicts of interest with us and the products or services utilized by us.
5. Some information, such as HIV-related information, genetic information, alcohol and/or substance use disorder treatment records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.
6. As a healthcare provider, we may receive substance use disorder records, which are protected under title 42 of the Code of Federal Regulations Part 2. In no event will we use or disclose your Part 2 Program record, or testimony that describes the information contained in your Part 2 Program record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against you, unless authorized by your consent or the order of a court after it provides you notice of the court order.
7. If you pay for your dental treatment and request that we not disclose the procedure to your insurance company we must comply with your request as long as you pay in full for the procedure in a timely manner.
8. You have the right to request a copy of your health records and to request the type of format you want (paper or electronic). If you request, in writing, that a copy of your records be sent to a specific third party, we are required to send them as directed and in a timely manner.
9. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

PATIENT ACKNOWLEDGEMENT

I have had an opportunity to read and consider the contents of this Notice of Privacy Practices. I understand that, by signing this form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations. I understand that I may request in writing that you restrict how my private health information is used or disclosed

PATIENT/GUARDIAN NAME:(PRINT) _____

RELATIONSHIP TO PATIENT: _____

SIGNATURE: _____ DATE: _____

HOW MAY WE CONTACT YOU? Email _____ Text _____ Mobile Phone _____