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FAMILY REGISTRATION FORM

RESPONSIBLE PARTY

Full Name:____ Birthdate:______________________

Street Address_______________________________________ City_______________________ State ____ Zip:________

Phone: (Home) __________________________ (Cell) ______________________ (Work) _________________________

May we contact you at work? Yes ___ No ___ E-Mail____

Driver's License # ______________________________________ Social Security # ________________________________

Employer Name____

Employer Address____

Emergency Contact: ____ Phone_____________________________________

How did you hear about our office?____

SPOUSE INFORMATION

Spouse Name ____ Birthdate _______________________

Phone: (Cell) _________________________________ (Work) _______________________________

May we contact you at work? Yes___ No ___ Email: ____

Employer Name____

Employer Address ____

FAMILY MEMBER INFORMATION

First Name | Last Name | Sex | Birthdate

(1)____

(2) ____

(3) ____

(4) ____

(5) ____

(6) ____

DENTAL INSURANCE INFORMATION

Subscriber Name ____ Birthdate _______________________________

Member ID # ____ S.S. # _______________________________________

Insurance Company ____ Group # _______________________

Insurance Co. Address ____ Phone # _____________________

Does this plan cover all family members? Yes ___ No___ Those not covered ____

ADDITIONAL DENTAL INSURANCE INFORMATION

Subscriber Name ____ Birthdate _________________________________

Member ID #____ S.S. #____________________________________

Insurance Company ____ Group # _______________________

Insurance Co. Address ____ Phone # _____________________

Does this plan cover all family members? Yes ___ No ___ Those not covered ______________________________________

PATIENT RELEASE/HIPAA/FINANCIAL POLICY

Patient Name: ____

Thank you for the confidence you have shown in choosing us to provide for your dental needs. We are pleased to assist with your insurance (if applicable); however, you are ultimately responsible for payment of your bill.

1. **AUTHORIZATION TO RELEASE INFORMATION :** I hereby authorize the release of my Protected Health Information (PHI) acquired in the course of my examination or treatment (typically x-rays, but could include health history, diagnosis, treatment or payment records), via electronic transmission, including emails without special encryption, to my insurance company to secure payment for services or to other dental providers required to participate in my care. I further authorize the below-named parties have access to my PHI and do acknowledge any party providing insurance coverage or financial responsibility will have access to my PHI.

   _______________________________________ Please Circle: Spouse Parent Child Other

   Signature of Patient/Legal Guardian: ____________________________ Date:_________________

2. **ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES :** I acknowledge that The Notice of Privacy Practices is kept at the location in which I am receiving treatment and that I have read and understand the notice. I further acknowledge that I have the right to request a copy of the Notice and one will be provided to me.

   Signature of Patient/Legal Guardian: ____________________________ Date: _________________

3. **FINANCIAL RESPONSIBILITY:** I understand I am personally responsible for any fees/copays I incur for services rendered and that those fees are due at the time of service. (For minor patients, the accompanying adult and parents/guardian are responsible for full payment.) I acknowledge I am responsible for any charges incurred by not providing the most current, correct insurance at time of service. Finance charges may be assessed against overdue accounts. In the event any fees are unpaid and it becomes necessary to pursue collection efforts, I agree to pay all costs directly associated with such collection efforts. I acknowledge any demographic information provided by me, including my cellular phone number, may be used to contact me for any purpose, including collection efforts. I also understand that unless I cancel an appointment 24 hours in advance, the policy is to charge $50 per missed appointment.

   I authorize payment for services rendered to be paid by any third party; including, but not limited To, insurance carriers directly to Adiska Family Dental.

   Signature of Patient/Legal Guardian: ___________________________ Date: _________________

TREATMENT AUTHORIZATION AND CONSENT

I hereby authorize Adiska Family Dental and whomever they may designate as their associates, and or assistants, to perform dental treatment upon me / my child

Print Patient Name: ____

If any unforeseen condition arises in the course of treatment calling for, in their judgment, procedures in addition to or different from those now contemplated, I further authorize and request Adiska Family Dental to do whatever they deem advisable.

The following information is not presented to worry you, but rather, in order to conform to the principles of **INFORMED CONSENT**. Any dental procedure or anesthetic may result in certain postoperative effects. These could include infection, postoperative bleeding, swelling and or bruising, Discomfort, stiff jaws. Less common complications can include loss of loosening of dental restoration, loss of or injury to adjacent teeth and soft tissues, nerve disturbances (e.g. numbness In mouth, lips or tongue. Only in rare instances is this permanent), broken jaws, sinus exposure, swallowing or inhaling of teeth or restorations and injury to the ligaments or muscles of the jaw joint, (TMJ). The utmost care will be given to minimize the possibility of these complications.

I further consent to the administration of local anesthesia, antibiotics, or any other drugs that may be deemed necessary in my case, and I understand that there is a slight element of risk inherent in the administration of any other drugs or anesthesia.

I realize that it is mandatory that I give as accurate and complete medical and personal history as possible, and will follow any and all postoperative instructions as directed and permit prescribed diagnostic procedures.

I further realize that in spite of the possible complications, my contemplated treatment is necessary and desired by me. I am aware that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me concerning the results or treatment.

I have read and understand the above explanation and I consent to treatment and the administration of anesthesia, and any other procedures which may be deemed necessary at the time of treatment. A full explanation of all complications is available to me upon request from the Doctor.

Print Name:____

Signature Patient/Guardian:________________________________ **Date:**______________________

(Parent or Guardian must sign for patients under 18)

Medical History

Patient Name:

Date of Birth:

Sex:

Emergency Contact:

Emergency Contact Phone:

Emergency Contact Relationship:

Do you have any of the following diseases or problems

Active Tuberculosis .... Yes No

Persistent cough greater than a 3 week duration .... Yes No

Cough that produces blood .... Yes No

Been exposed to anyone with tuberculosis .... Yes No

Medical History

Are you now under the care of a physician? .... Yes No

Physician Name ____________________

Phone (including area code) ____________________

Address/City/State/Zip ____________________

Are you in good health? .... Yes No

Has there been any change in your general health within the past year? .... Yes No

If yes, what condition is being treated?____________________

Date of last physical exam ____________________

Have you had a serious illness, operation or been hospitalized in the past 5 years? .... Yes No

If yes, what was the illness or problem? ____________________

Are you taking or have you recently taken any prescription or over the counter medicine(s)? ..... Yes No

If so please list all, including vitamins, natural or herbal preparations and/or diet supplements ____________________

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Do you wear contact lenses? .... Yes No

Joint replacement. Have you had any orthopedic total joint (hip, knee, elbow, finger) replacement.. Yes No

Date ____________________

If yes, have you had any complications? ____________________

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax) or risedronate (Actonel) for osteoporosis or Paget's disease?.. Yes No

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia or Zometa) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? .... Yes No

Date treatment began ____________________

Do you use controlled substances (drugs)? .... Yes No

Do you use tobacco (smoking, snuff, chew, bidis)? .... Yes
No

If so, are you interested in stopping? VERY/ SOMEWHAT/ NOT INTERESTED ____________________

Do you drink alcoholic beverages? .... Yes No

If yes, how much alcohol did you drink in the last 24 hours? ____________________

If yes, how much do you typically drink in a week? ____

Women ONLY. Are you:

Pregnant ………………………………………………………………………………………… Yes No

Number of weeks ____

Taking birth control pills or hormonal replacement? ………………………………………… Yes No

Nursing? ……………………………………………………………………………………..... Ye

Allergies, Are you allergic to or have you had any reaction to

Local anesthetics …………………………... Yes No

Aspirin ……………………………………….. Yes No

Penicillin or other antibiotics ………………. Yes No

Barbiturates, sedatives, or sleeping pills…. Yes No

Sulfa drugs ………………………………….. Yes No

Codeine or other narcotics ………………… Yes No

Metals ……………………………………….. Yes No

Latex (rubber) ……………………………….. Yes No

Iodine …………………………………..Yes No

Hay fever/ seasonal ……………….....Yes No

Animals ……………………………....Yes No

Food ………………………………….....Yes No

Other …………………………………...Yes No

If Other, please specify:

____

Congenital Heart Disease (CHD) - Please indicate if you have had or not had any of the following:

Artificial (prosthetic) heart valve ………….. Yes No

Previous infective endocarditis …………… Yes No

Damaged valves in transplant heart …….. Yes No

Congenital heart disease (CHD) ………….. Yes No

Unrepaired, cyanotic CHD ………………... Yes No

Repaired (completely) in the last 6 months.. Yes No

Repaired CHD with residual defects ………. Yes No

Other Diseases and Conditions - Please indicate if you have had or not had any of the following:

Cardiovascular disease …………………… Yes No

Angina ………………………………………. Yes No

Arteriosclerosis …………………………….. Yes No

Congestive heart failure …………………… Yes No

Damaged heart valves …………………….. Yes No

Heart attack ………………………………… Yes No

Heart murmur ………………………………. Yes No

Low blood pressure …………………………Yes No

High blood pressure ……………………….. Yes No

Other congenital heart defects ……………. Yes No

Mitral valve prolapse ………………………. Yes No

Pacemaker ………………………………….. Yes No

Rheumatic fever ……………………………. Yes No

Rheumatic heart disease ………………….. Yes No

Abnormal bleeding ………………………… Yes No

Anemia ……………………………………….... Yes No

Blood transfusion …………………………… Yes No

If yes, date ____________________________

Hemophilia …………………………………... Yes No

AIDS or HIV …………………………………. Yes No

Arthritis ………………………………………. Yes No

Autoimmune disease ………………………. Yes No

Rheumatoid arthritis ……………………….. Yes No

Systemic lupus erythematosus …………… Yes No

Asthma ………………………………………. Yes No

Bronchitis ……………………………………. Yes No

Emphysema ……………………………….... Yes No

Sinus trouble ……………………………….. Yes No

Tuberculosis ……………………………….. Yes No

Cancer/Chemotherapy/Radiation Treatment Yes No

Chest pain upon exertion ………………… Yes No

Chronic pain ………………………………… Yes No

Diabetes Type I or II ……………………….. Yes No

Eating disorder ……………………………… Yes No

Malnutrition …………………………………. Yes No

Gastrointestinal disease ………………….. Yes No

G.E. Reflux/persistent heartburn ………… Yes No

Thyroid problems ………………………….. Yes No

Stroke ……………………………………..... Yes No

Glaucoma …………………………………... Yes No

Hepatitis, jaundice or liver disease………. Yes No

Epilepsy …………………………………… Yes No

Fainting spells or seizures ………………. Yes No

Neurological disorders ………………….. Yes No

If yes, please specify ________________________

Sleep disorder …………………………. Yes No

Mental health disorders ………………. Yes No

Specify ____________________________________

Recurrent infections …………………… Yes No

Type of infection ______________________________

Kidney problems ………………………. Yes No

Night sweats …………………………… Yes No

Osteoporosis …………………………… Yes No

Persistent swollen glands in neck …… Yes No

Severe headaches/migraines………… Yes No

Severe or rapid weight loss …………. Yes No

Sexually transmitted disease ………... Yes No

Excessive urination ………………….. Yes No

Premedication

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?... Yes No

Name of physician or dentist making recommendation (include phone number) ______________________________

Do you have any disease, condition, or problem not listed above that you think I should know about?............ Yes No

Please explain ____

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Signature of Patient/Legal Guardian