PATIENT REGISTRATION

Page 1

PATIENT REGISTRATION

CONTACT INFORMATION

○ Dr. ○ Mr. ○ Mrs. ○ Ms. ○ Mx

Patient Last Name *

Patient First Name *

Initial

Preferred Name

Sex

○ Female ○ Male ○ Other

Cell Phone

Home Phone

Work Phone

Ext

Social Security#

Email

Preferred Number

○ cell ○ home ○ work

Marital Status

Spouses' Name

Address *

Apartment #

City *

State *

PA

Zip Code *

Employer

Occupation

Emergency Contact

Last Name

First Name

Emergency Contact #

REFERRAL INFORMATION

How did you find out about our office?

Who may we thank for referring you to our practice?

Reason for choosing Verber Family Dentistry?

RESPONSIBLE PARTY (IF OTHER THAN PATIENT)

Last Name

First Name

MI

Sex

○ Female ○ Male

Relationship to Patient

Address

City

State

Zip Code

Cell Phone

Home Phone

Work Phone

Ext

Email

INSURANCE INFORMATION

Primary Carrier

Do you have Primary Dental Insurance?

○ Yes ○ No

Our goal is to provide you with extraordinary care and service. Is there anything we can do to give you the best experience?

Date

Relationship to Patient

Please sign in box above

DENTAL HEALTH RECORD

DENTAL HEALTH RECORD

○ Dr. ○ Mr. ○ Mrs. ○ Ms.

Patient's Last Name *

Patient's First Name *

Initial

Date of Birth *

Sex

○ Female ○ Male

DENTAL CONCERNS & PREFERENCES

What are your primary dental concerns?

Importance of Each: circle on a scale of 1 (lowest) to 5 (highest)

Preventative Care

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Cost & Affordability

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Overall Wellness

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Appearance of Smile

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Extraordinary Service

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Extraordinary Quality of Treatment

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Freedom from Pain

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Avoiding Dentures / Removable Teeth

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

When discussing treatment I prefer

○ BIG PICTURE ○ DETAIL BY DETAIL

Do you feel nervous about dental treatment?

○ YES ○ NO

Have you had a bad dental experience?

○ YES ○ NO

Is there something we can do to make you more comfortable?

DENTAL HISTORY

When was your last dental visit?

Reason for visit?

Name of previous dentist

Location (City / State)

Date of last exam

Date of last xray(s)

Date of most recent treatment

Sensitive Teeth
○ Present ○ Past ○ None

Clenching / Grinding
○ Present ○ Past ○ None

Oral Surgery / Extractions
○ Present ○ Past ○ None

Bleeding Gums
○ Present ○ Past ○ None

Orthodontic Treatment
○ Present ○ Past ○ None

Dental Implants
○ Present ○ Past ○ None

Bad Breath
○ Present ○ Past ○ None

Perio Treatment
○ Present ○ Past ○ None

Cold Sores
○ Present ○ Past ○ None

Loose Teeth
○ Present ○ Past ○ None

Smoking / Tobacco
○ Present ○ Past ○ None

Freq. Sugary Drinks/ Juices
○ Present ○ Past ○ None

AESTHETICS

Smile aesthetics expectations:
○ LOW ○ MEDIUM ○ HIGH

Are you happy with your smile?
○ YES ○ NO

TMJ

Have you ever been diagnosed with a problem with either jaw joint?
○ YES ○ NO

Does your jaw click, pop, or make noise when you open or close?
○ YES ○ NO

Has your jaw ever locked open or closed?
○ YES ○ NO

Do you get headaches?
○ YES ○ NO

Do you clench or grind your teeth or been told that you do?
○ YES ○ NO

Do you have a history of trauma to your chin or jaw?
○ YES ○ NO

Have you worn a nightguard?
○ YES ○ NO

SLEEP

Have you ever been diagnosed with sleep apnea?
○ YES ○ NO

Do you wear a CPAP or dental appliance?
○ YES ○ NO

Do you snore?
○ YES ○ NO

Please sign in box below

Date *

PATIENT MEDICAL RECORD

PATIENT MEDICAL RECORD

○ Dr. ○ Mr. ○ Mrs. ○ Ms.

Patient's Last Name *

Patient's First Name *

Initial

Date of Birth *

Sex

○ Female ○ Male

What is your general state of health?

○ Excellent ○ Good ○ Fair ○ Poor

Primary Physician

Name

Address

Phone #

Specialist

Type

Name

Address

Phone # (___) ___-____

Specialist

Type

Name

Address

Phone # (___) ___-____

Have you been under a physician's care during the last two years?

○ YES ○ NO

Have you been treated in a hospital in the past three years?

○ YES ○ NO

Have you had major surgery?

○ YES ○ NO

History with general or IV anesthesia?

○ YES ○ NO

Have you ever taken drugs for osteoperosis/penia?

○ YES ○ NO

If female: Are you pregnant or nursing?

○ YES ○ NO

Do you have any food allergies?

○ YES ○ NO

Has it ever been recommended that you take antibiotics prior to dental visits?

○ YES ○ NO

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

Heart Disease
○ Present ○ Past ○ None

Anemia / Sickle Cell
○ Present ○ Past ○ None

Acid Reflux / GERD
○ Present ○ Past ○ None

Heart Failure
○ Present ○ Past ○ None

Leukemia
○ Present ○ Past ○ None

Stomach Ulcer
○ Present ○ Past ○ None

Angina
○ Present ○ Past ○ None

HIV+ / AIDS
○ Present ○ Past ○ None

Autoimmune Disease
○ Present ○ Past ○ None

Mitral Valve Prolapse
○ Present ○ Past ○ None

Fainting/Dizzy Spells
○ Present ○ Past ○ None

Thyroid Disease
○ Present ○ Past ○ None

Rheumatic Fever
○ Present ○ Past ○ None

Lung Disease
○ Present ○ Past ○ None

Fibromyalgia
○ Present ○ Past ○ None

Congenital Heart Lesion
○ Present ○ Past ○ None

Asthma
○ Present ○ Past ○ None

Arthritis
○ Present ○ Past ○ None

Artificial Heart Valves
○ Present ○ Past ○ None

Emphysema / Bronchitis
○ Present ○ Past ○ None

Osteoporosis/Penia
○ Present ○ Past ○ None

Stent
○ Present ○ Past ○ None

Tuberculosis / PPD+
○ Present ○ Past ○ None

Psychiatric Disorder
○ Present ○ Past ○ None

Heart Surgery
○ Present ○ Past ○ None

Cancer
○ Present ○ Past ○ None

Epilepsy / Seizures
○ Present ○ Past ○ None

Pacemaker
○ Present ○ Past ○ None

Radiation Therapy
○ Present ○ Past ○ None

Cerebral Palsy
○ Present ○ Past ○ None

High Blood Pressure
○ Present ○ Past ○ None

Chemotherapy
○ Present ○ Past ○ None

Penicillin Allergy
○ Present ○ Past ○ None

Stroke
○ Present ○ Past ○ None

Kidney Disease
○ Present ○ Past ○ None

Codeine Allergy
○ Present ○ Past ○ None

Diabetes
○ Present ○ Past ○ None

Liver Disease
○ Present ○ Past ○ None

Novocain Allergy
○ Present ○ Past ○ None

Bleeding Problem / Bruises
○ Present ○ Past ○ None

Hepatitis A,B
○ Present ○ Past ○ None

Aspirin Allergy
○ Present ○ Past ○ None

Hemophilia
○ Present ○ Past ○ None

Hepatitis C
○ Present ○ Past ○ None

Sulfa Allergy
○ Present ○ Past ○ None

Latex Allergy
○ Present ○ Past ○ None

Do you have any condition, disease or problem not previously listed?

Are you allergic to any medications not listed above?

○ YES ○ NO

Please list all the medications you are taking, including over the counter drugs and herbs:

Medications	Dosage / Day	Reason

Date *

Please add signature in box above

Consent to treat a minor/child

Search Dental – Consent to treat a minor/child

In providing dental care, we will treat your child as we would our own. Dentistry is an important health service for your child, and it is our goal to provide him/her with a satisfying experience in our office. Please read this form carefully. Should you have any questions, our office staff will be delighted to help you.

1. I hereby authorize and direct doctors and staff at Search Dental to perform dental treatment with the use of any necessary or advisable radiographs (x-rays) and/or any other diagnostic aids in order to complete a thorough diagnosis and treatment plan. I understand certain parts of the treatment may be performed by dental assistants and hygienists.
2. I understand x-rays, photographs, models of the mouth, and/or any other diagnostic aid used for an accurate diagnosis and treatment planning are the property of the doctor, but copies are available upon request.
3. In general terms, the dental procedure(s) can include but not be limited to comprehensive oral examination, radiographs, cleaning of the teeth and the application of topical fluoride, application of sealants to the grooves of the teeth, treatment of diseases or injured teeth with dental restorations, stainless steel or composite crowns and/or root canal treatment, oral surgery, extraction of one or more teeth, excision of hyperplastic and/or pericoronal tissue, exposure of unerupted tooth, placement of space maintainers and/or replacement of missing teeth with dental prosthesis, treatment of diseases or injured oral tissues secondary to traumatic injuries and/or accidents and/or infection, treatment of habits, malposed (crooked) teeth, orthodontics and/or oral dental development or growth abnormalities
4. I authorize the use of accepted behavior management techniques including nitrous oxide analgesia in order to complete treatment for my child. I understand that the doctor is not responsible for previous dental treatment. I understand that in the course of treatment, this previously existing dentistry may need adjustment and/or replacement. I realize that guarantees of results or absolute satisfaction are not possible in dental health service.
5. I have answered all the questions about my or me dependent's medical history and present health condition fully and truthfully. I have told the dentist or other office personnel about all conditions, including allergies, which might indicate that my child should receive oral medications. I also understand if I or my dependent ever had any changes in health status or any changes in medication(s) I will inform the doctor at the next appointment.
6. I authorize other individuals with whom I have places the care of my child, such as other family members, caregivers to sign consent for dental treatment for my child should they bring my child to any future appointments.

I hereby acknowledge that I have read & understand this consent and the meaning of it's contents. All questions have been answered in a satisfactory manner and I believe I have sufficient information to give informed consent for treatment. I further understand that this consent shall remain in effect until terminated by me.

Patient's First Name *

Patient's Last Name *

Date *

~

*

Relationship to Patient

Rngcug"c f f"uki pcwtg"kp"dqz"cdqxg

RELEASE & PHOTO IMAGE CONSENT

SEARCH DENTAL

RELEASE & PHOTO IMAGE PUBLICATION CONSENT VERIFICATION AGREEMENT

Search Dental is dedicated to improving standards of care through the delivery of extraordinary treatment, research and sharing of expertise. This photo release allows us to lecture, teach, publish and learn in the pursuit of dental excellence. If you have any questions or concerns with this agreement please feel free to discuss them with a treatment coordinator or your dentist prior to signing.

Patient's First Name *

Patient's Last Name *

This AGREEMENT is for the purpose of identifying any express or implied agreement, including, but not limited to, permission, consent, release, and/or authorization between DENTIST/PRACTICE and PATIENT in connection with the medical services PATIENT received from DENTIST / PRACTICE.

DENTIST / PRACTICE and PATIENT warrant and represent that PATIENT has given CONSENT and FULL AUTHORIZATION that any photographs and/or images of PATIENT, under the following conditions.

1. The photographs and/or images & videos will be taken by DENTIST/PRACTICE or by a photographer and/or skilled operator approved by DENTIST/PRACTICE.

2. The photographs and/or images may be used for:

a. Identification purposes, medical records, and if in the judgment of DENTIST/PRACTICE, medical research, education or science will be benefited by their use. Such photographs and/or images and information relating to PATIENT may be published or republished, either separately or in connection with each other, in but not limited to, professional journals, medical books, medical based Internet websites, or any other purpose which DENTIST / PRACTICE may deem proper in the interest or, but not limited to, medical education, knowledge, or research; and or

b. PATIENT further authorizes that the photographs and/or images may be used by DENTIST/PRACTICE or by an entity approved by DENTIST/PRACTICE in promotional printed, computer website and / or video material.

- ○ OK to use full face images for promotional & video material
- ○ Please refrain from using full face images in promotional material

3. At no time will PATIENT'S name, address, or any other alpha/numeric PATIENT identifiable information be used in connection with the publication of the photographs and / or images of PATIENT. PATIENT acknowledges the possibility that his/her identity may become known as a result of the publication and use of the photographs and / or images described in paragraph 2; above.

4. The photographs and / or images & video may be modified and / or retouched in any way in DENTIST'S / PRACTICE discretion.

By signing below, PATIENT certifies that he / she has read and understood each and every section of this Agreement, and agrees to be bound by its terms.

Please add signature in box above

DATE *

DATE *

Notice of Privacy Practices Acknowle

NOTICE OF PRIVACY PRACTICES

PATIENT ACKNOWLEDGEMENT

PLEASE READ THE FOLLOWING STATEMENTS 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 operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides 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 our Notice accompanies this Consent. We encourage you to read it 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.

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. Please understand that revocation of this Consent will not affect any action we 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.

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

I had the opportunity to review and/or obtain a copy of this office's Notice of Privacy Practices.

Patient's First Name *

Patient's Last Name *

Birth Date *

*

Relationship to Patient

(if signed by personal representative of patient)

Date *

Rtgcug"uki p" j gtg

☐ Please check the box if we are able to leave a message with medical & financial information on phone numbers

Please list individuals names that we are allowed to release financial and medical information to:

1

2

** You May Refuse to Sign This Acknowledgment**

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ○ Individual refused to sign
- ○ Communications barriers prohibited obtaining the acknowledgement
- ○ An emergency situation prevented us from obtaining acknowledgement
- ○ Other

INSURANCE AGREEMENT

SEARCH
DENTAL

INSURANCE AGREEMENT

Dear Patient,

We have prepared this letter to help you better understand the complexities of dental insurance. We realize how confusing it can be. To begin, we would like to highlight a misconception--dental insurance is not designed to pay for all dental care. Most contracts have limits and/or various degrees of co-payment. However, at Search Dental we are committed to working with you and your insurance company in order to provide the best and most affordable treatment.

All levels of payment by insurance companies, including allowed fees and UCR's (usual and customary rates), are governed by the premiums they are paid. They do not reflect actual dental costs. Our fees are based upon a combination of our costs, our time, and our constant dedication to supplying our patients with the highest quality dental care. The treatment recommended by our office is never based on the restraints of your insurance contract.

It should be understood that the dental insurance contract is between the insurance company and the patient, whom bears the ultimate financial responsibility. All estimated co-pays for treatment performed at our office is due at the time of service.

We hope this information has been helpful. Please take the time to review your insurance contract thoroughly so we may best serve you. As always, you may feel free to ask any member of our staff for clarification on services, billing, and insurance.

Patient's First Name *

Patient's Last Name *

Date *

Rngcug"c f f"uki pcwtg"kp"dqz"cdqxg