

TIME _____

DATE _____

PATIENT REGISTRATION

ID: _____

Chart ID: _____

First Name: _____

Last Name: _____

Middle Initial: _____

Patient Is: ☐ Policy Holder ☐ Responsible Party

Preferred Name: _____

Patient Information

Address: _____ Address 2: _____

City: _____ State / Zip: _____ Pager: _____

Home Phone: _____ Cell Phone: _____ ☐ I would like to receive text reminders. Work _____Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: _____ Age: _____ Soc Sec: _____ Drivers Lic: _____

E-mail: _____ ☐ I would like to receive correspondences via e-mail.

Section 2

Section 3

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Language Spoken _____

Student Status: ☐ Full Time ☐ Part Time

How were you referred to our office? _____

Pref. Dentist: _____ Pref. Hygienist: _____

Pref. Pharmacy: _____

Responsible Party (if someone other than the patient)

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

Address: _____ Address 2: _____

City, State, Zip: _____ Text: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder**Primary Insurance Information**Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____

Ins. Company: _____

Address: _____

Address: _____

Address 2: _____

Address 2: _____

City, State, Zip: _____

City, State, Zip: _____

Rem. Benefits: _____ Rem. Deduct: _____

Secondary Insurance InformationName of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____

Ins. Company: _____

Address: _____

Address: _____

Address 2: _____

Address 2: _____

City, State, Zip: _____

City, State, Zip: _____

Rem. Benefits: _____ Rem. Deduct: _____

Medical History

Patient Name:

Birth Date:

Date Created:

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

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

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

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

Other? ☐ If yes
 Do you use controlled substances? ☐ Yes ☐ No If yes

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

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

Have you ever had any serious illness not listed ☐ Yes ☐ No If yes

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:

X

Date: _____

CONSENT FORM

PATIENTS NAME _____
Last First Initial Date of Birth

I hereby authorize Dr. Lorraine Celis,

And whomever he/she may designate as his/her assistants, to perform upon me the following operation and or procedures:

I request and authorize him/her to do whatever he/she deems advisable if any unforeseen condition arises in the course of these designated operations and or procedures calling, in their judgement, for procedures in addition to or different from those now contemplated.

I consent to the above treatment after having been advised of the risks, advantages and disadvantages of the treatments and consequences if this treatment were withheld.

I further consent to administration of local or general anesthesia, antibiotics, analgesics or any other drugs that may be deemed necessary in my case, and understand that there is a slight element of risk inherent in the administration of any drug or anesthesia. This risk includes adverse drug response (e.g., allergic reactions), cardiac arrest, and aspiration, and thrombophlebitis (e.g. irritation and swelling of a vein), pain, discoloration and injury to blood vessels and nerves which may be caused by injections of any medication or drugs.

I am informed and fully understand that inherent in any type of surgery are certain unavoidable complications. In oral surgery, the most common of these complications include post-operative bleeding, swelling or bruising, discomfort, stiff jaws, loss or loosening of dental restorations. Less common complications can include infection, loss or injury to adjacent teeth and soft tissues, nerve disturbances (e.g., numbness in mouth and lip tissues), jaw fractures, sinus exposure and swallowing or aspiration of teeth and restorations, and small root fragments remaining in the jaw which might require extensive surgery for removal.

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

I have provided as accurate and complete a medical and personal history as possible including those antibiotics, drugs, medications and foods to which I am allergic. I will follow any and all instructions as explained and directed to me and permit prescribed diagnostic procedures.

I have had the opportunity to ask questions and receive answers to and responsive explanations for, all questions about my medical condition, contemplated and alternative treatment and procedures, prior to signing this form.

Patient or Guardian's Signature _____ Date _____

Dentist's Signature  Date _____

Witness's Signature _____ Date _____

JEFFERSON DENTAL CENTER

Financial Policy

We are committed to providing you with the best possible care. If you have dental insurance we will help you to receive your maximum allowable benefits. In order to do this, we need your assistance and your understanding of our financial policy.

Payment for service is due at the time services are provided unless other payment arrangements have been approved in advance. We accept cash, checks and most credit cards and also have financing options. We will be happy to process your insurance claims as a courtesy. If we bill your account you may be subject to a \$1.00 billing fee.

We will gladly discuss your proposed treatment and answer any question relating to your insurance, to the best of our ability, however, you must realize the following:

1. **Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. _____ (initials)**
2. **Dental insurance is not meant to be a pay-all: it is only meant to be an aid. Many routine dental services are not covered by insurance at all. Jefferson Dental Center will do their best to give me an estimate of what my out-of-pocket expenses will be, however, can not guarantee payment by my insurance. _____ (initials)**
3. **Jefferson Dental Center will file my claims as a courtesy, I understand that I am responsible for all charges regardless of my insurance status. I understand that I am responsible for all charges incurred through collection activity should my account go delinquent. _____ (initials)**
4. **I understand that I may be charged a \$25.00 fee for failed appointments or appointments cancelled without a 24 hour notice. _____ (initials)**
5. **I understand that if I write a check and the check is returned for non-sufficient funds I will be charged \$25.00 to my account. _____ (initials)**

We must emphasize that as a dental care provider, our relationship is **not** with your insurance company. If you have any questions regarding your coverage, you should contact your insurance company regarding the details of the plan. It is your responsibility to know your insurance coverage.

Signature of Account Holder

Date

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient #: _____ Social Security #: _____

SECTION B: TO THE PATIENT — 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.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Mont Annis

Telephone: (574) 233-7266 Fax: (574) 233-7560

E-mail: mont@jeffersondentalcenter.com

Address: 2628 East Jefferson Boulevard South Bend, IN 46615

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.

SIGNATURE

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 health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include completed Consent in the patient's chart.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement*

I, _____, have received a copy of this
office's Notice of Privacy Practices.

Please Print Name

Signature

Date

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 (Please Specify)

Jefferson Dental Center, Inc.

HIPAA OMNIBUS RULE PATIENT ACKNOWLEDGMENT FORM

PURPOSE: This form is to obtain an individual's permission for our use of the individual's patient health care records to carry out **treatment, payment activities, and health care operations**. This consent is a condition of your treatment by us. If you choose not to sign this consent, we may decline to treat you. 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 uses and disclosure of your protected health information (PHI) and of other important matters about your protected health information.

In signing this HIPAA patient acknowledgment and consent form, you acknowledge and authorize that this office may recommend products or services to promote your overall health. This office may or may not receive third party remuneration from these affiliated companies. We under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

How do you want to be acknowledged when being summoned from the reception area (please check one):

_____ By First Name Only _____ By Proper Sir Name (Mr. Mrs. Ms. With Last Name _____ Other

Please list any other parties that can have access to your health information, patient records, and all other (PHI) protected health information

Name: _____ Relationship: _____

Name: _____ Relationship: _____

OUR NOTICE OF PRIVACY PRACTICES ARE INCLUDED IN THIS CLIPBOARD, DISPLAYED AT THE FRONT DESK, AND ARE AVAILABLE FOR REVIEW ON OUR WEBSITE:

https://www.jeffersondentalcenter.com/Notice_of_Privacy_Policies.pdf

OUR DISCLOSURE OF DENTAL INFORMATION/OTHER CONSENT:

I, (print your name) _____ have been informed of this office's Notice of Privacy Practices. I understand by signing this form, I am confirming my written permission for the disclosure of my protected health information. (PHI)

Signature: _____ Date: _____

Parent/Legal Guardian (if minor):

_____ Date: _____