Registration and Dental History

Patient's Name (First): (Last): (Middle Initial):

Preferred Name: Date of Birth: Age: Sex: **MALE FEMALE**

Address : City, State, Zip:

Cell Phone#: Work #: Other #:

E-Mail: Best Contact: **EMAIL TEXT CELL HOME**

Social Security#: Driver's License #:

Marital Status: **SINGLE MARRIED WIDOWED SEPARATED DIVORCED**

Spouse's Name or (If a minor) Parent's Name:

Spouse's Work Phone: Cell #:

RESPONSIBLE PARTY INFORMATION

Responsible Party Name (if different from patient): Relationship:

Responsible Party Address, City, State, Zip:

Home Phone#: Work #: Cell #:

Employer: Employer Address:

INSURANCE & EMPLOYER INFORMATION

Insurance Carrier Name:

Subscriber's Name: Subscriber's Date of Birth:

Relation to Patient: **SELF SPOUSE CHILD OTHER** Subscriber's Phone #:

Subscriber's SS#: Insurance ID #: Group #:

Insurance Carrier Address, City, State, Zip:

Medicaid #:

Employment Status: **FULL TIME PART TIME UNEMPLOYED** Student Status: **FULL TIME PART TIME**

Employer: Phone #:

Employer Address, City , State, Zip:

DENTAL INFORMATION

Do your gums bleed when you brush? **YES NO Don't Know**

Have you ever had orthodontic (braces) treatment? **YES NO Don't Know**

Are your teeth sensitive to cold, hot, sweets or pressure? **YES NO Don't Know**

Do you have earaches or neck pains? **YES NO Don't Know**

Have you had any periodontal (gum) treatments? **YES NO Don't Know**

Do you wear removable dental appliances? **YES NO Don't Know**

How do you feel about the appearance of your teeth?

If you have a current dental problem, how would you describe it?

What was the name of your previous dentist? Office#:

Date of your last dental exam: Date of your last dental x-rays:

What was done at that time?

EMERGENCY CONTACT

Emergency Contact: Phone/Cell #:

(Please list closest relative or friend whose address is different from yours)

Relationship to Patient:

Emergency Contact Address, City, State, Zip:

Preferred Pharmacy: Phone #:

OTHER

How did you hear about us?

Have you or another member of your family been treated here? If so, who?

Would you like to receive appointment reminders via text messages; **YES NO** via email? **YES NO**

MEDICAL HISTORY

To help us to provide you with the safest and best care, please complete this Medical History form. All information is kept strictly confidential

Have you taken any prescription drugs during the last 6 months? Please list **YES NO**

Are you taking any over the counter medications or herbal supplements? Please list: **YES NO**

Are you under a physician's care? If so, name and phone # of Physician: **YES NO**

Have you had any surgeries and/or hospitalization? **YES NO**

Are you now having or have you ever had radiation to the head or neck? **YES NO**

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Please list: **YES NO**

Have you ever taken bone density medications for cancer or osteoporosis? **YES NO**

Have you ever or are you currently taking blood thinners? **YES NO**

Do you use tobacco? What type and how much per day? **YES NO**

Do you drink alcohol? If so, how much and how often?

Do you use "street drugs"? If so, which ones? **YES NO**

Are you pregnant? **YES NO** | Taking birth control? **YES NO** | Plan to become pregnant? **YES NO** | Nursing? **YES NO**

Are you allergic to any of the following?

◯ Aspirin ◯ Penicillin ◯ Peanuts ◯ Codeine ◯ Acrylic ◯ Local Anesthetics
◯ Metal ◯ Latex ◯ Bananas ◯ Sulfa Drugs ◯ Other_____

Mark any of the following that are not or were previously applicable:

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

Other, please explain:

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 office of any changes in medical status.

Print Patient Name

Signature of Patient or Guardian Date

Serenity Family Dentistry
Consent For Use and Disclosure Of Health Information

Print Name: _____ DOB: _____

PLEAE 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; 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: Office Manager of Serenity Family Dentistry
Telephone: 704-365-0006 Fax: 704-365-0007
Address: 3749 Latrobe Drive Charlotte, NC 28211

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 of 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.

Please list any persons you wish to have access to your account (Note: All areas of account will be accessible, unless documented below):

_____
_____
_____
_____

SIGNATURE: _____ DATE:_____
If not Patient, Print Name and Relation: _____

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*I **revoke** my consent for your use and disclosure of my protected health information for treatment payment activities and healthcare operations. I understand that revocation of my consent will not affect any action you took in reliance on my consent before you received this written notice of revocation. I also understand that you may decline to treat or to continue to treat me after I revoked my consent. I understand that revocation of my consent will prevent Dr. Attaway from accepting assignment of my insurance benefits and will be unable to file those for me. The office will complete a receipt as treatment is completed for you to file with your insurance company.*

Signature: _____ *Date:* _____

Serenity Family Dentistry Financial Policies and Release of Information

Thank you for choosing Serenity Family Dentistry for your dental health care. Our main concern is that you receive the proper and optimal treatment needed to restore your health.

Please understand that processing your claim and payment of your bill is considered part of your treatment. So that we may better serve you, we ask you to please read, sign and return this form to us prior to your treatment. If you have any questions or concerns regarding our payment policies, please do not hesitate to discuss them with us. All patients should provide accurate and complete insurance information prior to being seen by the doctor. We will ask that you present your insurance card upon check-in at each visit so that we can verify coverage and the estimated deductible/percentage for services.

- Deductible/estimated portion for office services are required at the time of service unless prior arrangements have been made.
- We accept Cash, Check, Debit Cards, Visa, MasterCard, Discover, AMEX and CareCredit.
- We will file your insurance claims for services as a courtesy. Once applicable insurance has paid, any remaining balance will be the responsibility of the patient due upon receipt of statement.
- You will receive a statement each month from us as a reminder to follow-up with your insurance company to ensure your claim has been processed. The balance on your account is due in full 60 days after the date of service regardless of insurance payment.
- Any account 60 days or older will assess finance charges at a rate of 1-1.5% per month, 18% per year.
- If your insurance company is one that reimburses you directly for services ex: Delta Dental, payment for services rendered will be collected in full at the time of service.
- Please be aware that some insurance plans have exclusions for services and/or waiting periods. Although we make every effort to notify you of such policies, we cannot be familiar with every insurance plan. You are responsible for any non-covered or denied services.
- We recommend that all patients contact their insurance company to better understand their benefits and how claims will be processed.
- If the patient is a minor (18 years and younger), the parent or guardian is responsible for payment of the account, in accordance with the policies outlined herein.

Missed Appointments: Please help us serve you and our other patients by keeping all scheduled appointments**.** If you are unable to keep an appointment please notify us (even after hours) at least 24 hours in advance 704.365.0006. Failure to notify us with in less than 24 hours of your appointment may result in a minimum broken appointment charge of $42.00.

R**eturned Checks**: For checks returned to us, as unpaid by your bank, we will charge you a $35.00 fee.

Past Due Accounts: Overdue accounts will be referred to a collection agency if more than 90 days past due. If your account goes to collection, you agree to be responsible for all fees involved in the collection process.

I certify that I have read and understand the "Financial Policies" and agree to all terms and conditions as stated above. I certify that the information that I have provided is correct to the best of my knowledge. I understand that it is my sole responsibility to verify insurance coverage and I also understand that it is my responsibility to inform Serenity Family Dentistry of any changes associated with my insurance status. I agree to make an in-full, prompt payment to Serenity Family Dentistry when billed for any and all charges not covered or paid by insurance. I hereby assign and direct to pay any and all benefits for dental services under this claim to Serenity Family Dentistry.

I authorize the release of any dental information to my primary care or referring physician, to consultants if needed and as necessary to process my insurance claims and prescriptions. I authorize the use of this signature on all my insurance claims.

Serenity Family Dentistry has my authorization to charge my credit card for any current or past due personal balance upon receiving my verbal or written permission.

Patient/Guardian Signature:_____ Date:_____

Serenity Family Dentistry
Parental Treatment Consent
For Child(ren) Under 18 Years of Age

I, _____, parent/legal guardian of the following child(ren):
_____,
give the below named person(s) permission to accompany my child to dental appointments, allowing them to make financial and treatment decisions on my behalf. I understand that medical history and consent must be updated and signed yearly by parent or guardian. I understand that VERBAL CONSENT CANNOT BE ACCEPTED.

I understand that the person bringing the child must be 18 years or older, must be listed below and will be asked to show a valid picture ID.

I understand that a child under the age of 18 years old must be accompanied by an adult whose name is listed below. This adult must remain in office with the child for the duration of the appointment.

I understand that in order to add/remove someone from the list, a parent or legal guardian must come in person with valid ID and sign a new consent.

Person(s) and Relationship to Patient:

Print Name	Relationship
Print Name	Relationship
Print Name	Relationship
Parent/Legal Guardian	Date: