GENERAL PATIENT INFORMATION

Patient Registration

Patient Information

Full Name: _____

Preferred Name: _____

Preferred Pronouns: _____

Date of Birth: _____

Sex: ☐ Male ☐ Female ☐ Other

Social Security Number: _____

Email Address: _____

Home Phone Number: _____

Cell Phone Number: _____

Home Address: _____

Primary Dental Insurance Company – Subscriber and Insurance Company Details

Subscriber Name: _____

Date of Birth: _____

Social Security: _____

Employer: _____

Policy Number: _____

Group Number: _____

Coverage Type: ☐ Individual ☐ Family

Insurance Company: _____

Company Phone Number: _____

Secondary Dental Insurance Company – Subscriber and Insurance Company Details

Subscriber Name: _____

Date of Birth: _____

Social Security: _____

Employer: _____

Policy Number: _____

Group Number: _____

Coverage Type: ☐ Individual ☐ Family

Insurance Company: _____

Company Phone Number: _____

I authorize the dentist to release any information, including diagnosis, treatment plans/records and radiographs to third party payers and/or health practitioners. I authorize and request that my insurance company (if applicable) pay directly to the dental group or dentist benefits that are, otherwise, payable to me. I understand that my dental insurance may pay less than the actual bill for service or may not cover certain treatment.

I hereby certify that the foregoing information is accurate and complete and that in consideration of treatment and services rendered to me or my dependents by this dental office, I accept responsibility and agree to be obligated to pay the office in accordance with its payment and credit terms and policies.

Signature: _____

PATIENT MEDICAL HISTORY

Patient's Medical History

Physician Information

Physician's Full Name: _____

City, State and ZIP: _____

Are you currently under a physician's Care? ☐ Yes ☐ No

If Yes, for what?

Have you been hospitalized in the last two years? ☐ Yes ☐ No

If Yes, for what?

Are you taking any medication, drugs or pills? ☐ Yes ☐ No

If so, please list the names and dosages of each:

Do you Smoke? ☐ Yes ☐ No How Much? _____

Women Only

Are you pregnant? ☐ Yes ☐ No Are you taking birth control pills? ☐ Yes ☐ No

Are you nursing? ☐ Yes ☐ No Are you on Hormone Therapy? ☐ Yes ☐ No

Patient's Current or Previous Conditions

Select any of the following if you presently have or have had the condition in the past:

Medical Alerts

- ☐ Allergic to Penicillin
- ☐ Allergic to Tetracycline
- ☐ Allergic to Aspirin
- ☐ Allergic to Codeine
- ☐ Allergic to 'Novocaine'
- ☐ Allergic to Latex Rubber
- ☐ Pre-Medication required
- ☐ Mitral Valve Prolaspe
- ☐ Heart Problems
- ☐ Pacemaker
- ☐ HIV Positive
- ☐ Prior Hepatitis

☐ Other

Medical Conditions

- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Chest Pain
- ☐ Congenital Heart Problem
- ☐ Artificial Heart Valve
- ☐ Heart Surgery
- ☐ High/Low Blood Pressure
- ☐ Rheumatic Fever
- ☐ Anemia
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Stroke
- ☐ Deep Vein Clot
- ☐ Hemophilia
- ☐ Excessive Bleeding when Cut
- ☐ Sickle Cell Disease
- ☐ Glaucoma
- ☐ Diabetes
- ☐ Excessive Thirst
- ☐ Scarlet Fever
- ☐ Thyroid Disease
- ☐ Parathyroid Disease
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Hepatitis A or B
- ☐ Yellow Jaundice
- ☐ Cancer
- ☐ X-Ray or Cobalt Treatment
- ☐ Chemotherapy
- ☐ Ulcers
- ☐ Gastrointestinal Upset
- ☐ Acid Reflux
- ☐ Lung Disease
- ☐ Tuberculosis
- ☐ Shortness of Breath
- ☐ Emphysema
- ☐ Asthma
- ☐ Sinus Trouble
- ☐ Hay Fever
- ☐ Frequent Cough
- ☐ Rheumatism
- ☐ Arthritis/Gout
- ☐ Osteoporosis
- ☐ Swelling of Feet/Ankles
- ☐ Artificial Joint Replacement
- ☐ Psychiatric Care
- ☐ Epilepsy or Seizures
- ☐ Extreme Nervousness
- ☐ Fainting or Dizziness
- ☐ Hypoglycemia
- ☐ Hives
- ☐ Cold Sores/Fever Blisters
- ☐ Venereal Disease
- ☐ Herpes
- ☐ Cortisone Treatment
- ☐ Chemical Dependency

PATIENT DENTAL HISTORY

Patient's Dental History

What is your primary reason for seeking dental care?

_____

Previous Dentist Information

Dentist's Full Name: _____

City, State and ZIP: _____

Month and Year of Last Visit: _____

What was done at your last visit? _____

Date of Last full mouth x-rays: _____

Reason for leaving previous dentist: _____

How often do you visit the dentist? ☐ Annual Check Up ☐ Twice a Year Check Up

☐ Only when I have a problem ☐ Other

Please choose the appropriate answer

Are you nervous about receiving dental treatment? ☐ Yes ☐ No

Do you gag easily? ☐ Yes ☐ No

Have you had previous problems with dental care? ☐ Yes ☐ No

If so, please explain?

Are your teeth sensitive to hot, cold, pressure or sweets? ☐ Yes ☐ No

Do you have problems with teeth/fillings breaking? ☐ Yes ☐ No

Are you aware of an uncomfortable bite? ☐ Yes ☐ No

Do your gums feel tender and/or bleed? ☐ Yes ☐ No

Does food catch between your teeth? ☐ Yes ☐ No

Have you had periodontal (gum) treatments? ☐ Yes ☐ No

Do you get sores in or around your mouth? ☐ Yes ☐ No

Do you have regular headaches, earaches or neck pains? ☐ Yes ☐ No

Do you grind or clench your teeth? ☐ Yes ☐ No

Do you hear a "clicking" sound when you open/close your mouth? ☐ Yes ☐ No

Does your jaw ever get "stuck?" ☐ Yes ☐ No

Do you have a Temporomandibular (TMJ) jaw disorder? ☐ Yes ☐ No

Are you missing teeth that have not been replaced? ☐ Yes ☐ No

Have you had excessive bleeding after an extraction? ☐ Yes ☐ No

Do you take any Bisphosphonate medication such as Fosamax, Boniva, Actonel, Aredia or Zometa? ☐ Yes ☐ No

Have you had mouth sores that take long to heal? ☐ Yes ☐ No

Do you have any dental implants? ☐ Yes ☐ No

Do you wear dentures (partials or full)? ☐ Yes ☐ No

Do you have any crowns (caps) or bridges? ☐ Yes ☐ No

Do you chew tobacco? ☐ Yes ☐ No

Do you have a dry mouth? ☐ Yes ☐ No

Are you unhappy with the appearance of your teeth? ☐ Yes ☐ No

Would you like your smile to look better? ☐ Yes ☐ No

Would you like whiter teeth? ☐ Yes ☐ No

Do you regularly use dental floss? ☐ Yes ☐ No

Do you brush at least once daily? ☐ Yes ☐ No

Is there anything else that you would like us to know?

I authorize the use of my radiographs [x-rays] and/or photographs for educational and promotional use in seminars, publications and the dental office web site. ☐ Yes ☐ No

I hereby certify that the foregoing information is accurate and complete and that I will notify the office of any changes in a timely manner. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in completion of this form.

Signature: _____

RAYMUND V. FAVIS

D.D.S., P.C.

Financial Policy

Payment for services, including deductibles and co-payments, are due at the time of the service unless other arrangements have been made prior to treatment. For appointments requiring two or more visits, payment for procedure or deductible and copay is required at the first visit. Payments may be made using cash, check, or credit cards. Any arrangements for third-party financing must be made before starting treatment.

Our office accepts most dental benefit plans, however we are only preferred providers, as of this 2023 calendar year, for specific plans under Anthem, Blue Cross Blue Shield Federal, Cigna DPPO, Delta Dental PPO plans, GEHA, Guardian, and Principal. You are responsible for making sure that your coverage is in force for all family members at the time of treatment and that all waiting periods have been met. If you have any concerns about your coverage, we advise you to call your insurance company before beginning treatment to check your benefits.

We are happy to submit the claims necessary to see that you make use of your benefits, however we cannot guarantee any payment from insurance carriers. Dental plans often do not cover all necessary services and may pay less than expected for services that are covered. You are responsible for any amount that is not covered by your plan.

Balances that are not paid within 60 days of insurance payment will incur a monthly service charge of 10% per month. Checks that are returned to our office from your financial institution are subject to a $35.00 returned check fee. If a patient fails to appear for a scheduled appointment without providing a 24 hour cancellation notice, there will be a **$50 cancellation** charge. This charge cannot be billed to insurance and must be paid on or before the next scheduled appointment. By signing below, you indicate your understanding and acceptance of these financial policies.

_____

Patient Name Printed

_____ _____

Patient, Guardian or Guarantor Signature Date

PATIENT HIPAA CONSENT FORM

You have certain rights to privacy regarding your protected health information. These rights are given to you under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This provides a safeguard to your privacy.

There are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). Theses restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other that office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient record, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by text message, telephone, or e-mail, as requested by you. We may send you other communications informing you of changes to office policy.
3. The practice utilizes a number of vendors (insurance carriers) in the conduct of business. These vendors may have access the PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies enforcing HIPAA compliance in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I _____ on this date of _____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in the office policy. I understand that this consent shall remain in force from this date forward.

Signature _____ Relationship to Patient _____