Prairie Smiles Family Dentistry – Patient Registration Form

1 Patient Information

Patient _____

Address _____

City _____

State _____ Zip _____

Email _____

Sex ○ M ○ F Birthdate _____

○ Single ○ Married ○ Widowed ○ Divorced

Patient SS# _____

Occupation/Employer_____

Spouse/Parent Name _____

Birthdate _____ SSN# _____

How you found out about our office?

○ Phonebook ○ Internet ○ Doctor ○ Friend

By whom _____

2 Phone Numbers – HIPAA

Check if you can leave messages on the following:

Home _____ ○

Work _____ ○

Cell _____ ○

It is ok to call or text my phone and leave messages regarding appointments, dental insurance benefits, financial arrangements and payments. ○ Yes ○ No

In Case of Emergency, contact

_____ Phone _____

You can leave messages/verbal information with:

Name _____

Phone _____Relationship _____

Name _____

Phone _____Relationship _____

○ I received a copy of this office's Notice of Privacy Practices.

Office use only: We attempted to attain acknowledgement of receipt of Notice of Privacy Practice but was unable to because: individual refused, communication barriers or emergency situation prevented us from obtaining acknowledgment. ○

3 Insurance & Financial responsibility

Primary Insurance _____

Subscriber _____ DOB_____

Address if different than patient _____

City ST Zip _____

ID# or SS# _____

Group # _____

Relationship to Patient _____

Who is responsible for this account? _____

Secondary Insurance _____

Subscriber _____ DOB_____

Address if different than patient _____

City ST Zip _____

ID# or SS# _____

Group # _____

Relationship to Patient _____

ASSIGNMENT – RELEASE – AUTHORIZATION

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____, and assign Dr. Abigail Faul all insurance/Medicaid benefits, if any, payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize any holder of medical information about me to release any information needed to determine these benefits or the benefits payable to related services. The dentist agrees to accept the charge determination of only those plans this office participated in as the full charge, and the patient is responsible for the deductible, coinsurance and non-covered services**.** **Coinsurance and the deductible are based upon the plan coverage and is due on the day of service.**

I understand that I am financially responsible for all charges whether covered by insurance or not. I understand that if I am unable to show proof of insurance, that I am responsible for payment in full at the time of service**. I understand that after 60 days, the bill becomes my responsibility to pay.**

_____ Date_____

Patient or responsible party signature

4 Dental History

Do you have a specific problem? ○ No ○ Yes, describe _____

Name of previous dentist _____ City_____ Phone _____

Date of last visit _____ Date of last x-rays _____ Do you have regular dental exams? ○ Yes ○ No

Do your gums bleed? ○ Yes ○ No Any loose teeth? ○ Yes ○ No Do you grind your teeth? ○ Yes ○ No

5 Medical History

NAME OF PRIMARY CARE PHYSICIAN:

_____City_____

Phone _____

Date of last visit _____

Have you ever had serious injury to head or neck?

_____

Any hospitalizations/major surgeries?

_____

_____

MEDICATIONS AND DOSAGES:

_____

_____

_____

_____

_____

_____

_____

PHARMACY:_____

City_____Phone_____

ALLERGIES: None ○

Aspirin ○	Acrylic ○
Codeine ○	Latex ○
Penicillin ○	Metal ○
NSAIDS ○	Other_____

_____

FOR WOMEN: Are you?

Pregnant ○
Nursing ○
Trying to get Pregnant ○
Taking contraceptives ○
None ○

Mark Yes or No if you have or have had any of the following:

Alzheimer's / Dementia	○ Yes ○ No
Anemia	○ Yes ○ No
Angina	○ Yes ○ No
Artificial Heart Valve	○ Yes ○ No
Artificial Joint	○ Yes ○ No
Asthma	○ Yes ○ No
Back Problems	○ Yes ○ No
Cancer / Chemotherapy	○ Yes ○ No
Circulatory Problems	○ Yes ○ No
Diabetes	○ Yes ○ No
Drug Addiction	○ Yes ○ No
Ear / Eye Problems	○ Yes ○ No
Epilepsy/Seizures/Convulsion	○Yes ○No
Fainting / Dizziness	○ Yes ○ No
Excessive Bleeding	○ Yes ○ No
Excessive Thirst	○ Yes ○ No
Headaches	○ Yes ○ No
Heart Disease	○ Yes ○ No
Heart Attack	○ Yes ○ No
Hepatitis	○ Yes ○ No
Herpes	○ Yes ○ No
High Blood Pressure	○ Yes ○ No
HIV / AIDS	○ Yes ○ No
Irregular Heartbeat	○ Yes ○ No
Kidney Disease	○ Yes ○ No
Liver Disease	○ Yes ○ No
Low Blood Pressure	○ Yes ○ No
Mitral Valve Prolapse	○ Yes ○ No
Nervousness / Anxiety	○ Yes ○ No
Pacemaker	○ Yes ○ No
Psychiatric Care	○ Yes ○ No
Radiation Treatment	○ Yes ○ No
Respiratory Disease	○ Yes ○ No
Shortness of Breath	○ Yes ○ No
Sinus Problems	○ Yes ○ No
Stroke	○ Yes ○ No
Swollen Neck / Glands	○ Yes ○ No
Thyroid Disease	○ Yes ○ No
Tuberculosis	○ Yes ○ No

Other _____

_____

TOBACCO USE: ◯ NO

Do you or have you ever used tobacco?
○ Yes, What Type? _____
How Long? _____
Frequency? _____

CANNABIS USE: ◯ NO

Do you or have you ever used Cannabis?
◯ Yes, What type? _____
How long? _____
Frequency?_____

ILLEGAL DRUG USE: ◯ NO

Do you or have you ever used illegal drugs?
◯ Yes, What type?_____
How long? _____
Frequency? _____

ALCOHOL USE: ◯ NO

Do you or have you ever used alcohol?
◯ YES # drinks per day___ per week___

6 Consent -- Acknowledgment

I hereby authorize Prairie Smiles Family Dentistry to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page is correct and to the best of my knowledge. I grant the right of the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or health professionals. I understand that where appropriate, credit bureau reports may be obtained.

I agree that the office may charge a $25 fee for returned checks and for failed appointments.

Date _____

_____
Patient or responsible party signature