Patient Registration Information

Patient Information

First Name: _____ Last Name: _____ M.I.: _____

Preferred Name: _____ Title (Mr., Mrs., Dr.): _____

Address 1: _____

Address 2: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Ext: _____

Cell Phone: _____ Text Messages OK? ☐Yes ☐No Preferred Number: ☐Home ☐Work ☐Cell

Email: _____ I would like correspondence via email: ☐Yes ☐No

Birth Date: _____ Social Security Number: _____

Sex: ☐Male ☐Female Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed ☐Child

Student status if dependent over 19 (for ins): ☐Nonstudent ☐Fulltime ☐Parttime School: _____

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ M.I.: _____

Address 1: _____

Address 2: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Ext: _____

Cell Phone: _____ Text Messages OK? ☐Yes ☐No Preferred Number: ☐Home ☐Work ☐Cell

Email: _____ I would like correspondence via email: ☐Yes ☐No

Birth Date: _____ Social Security Number: _____

Sex: ☐Male ☐Female Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed ☐Child

Primary Insurance Information **Please present insurance card to receptionist.**

Relationship to subscriber: ☐Self ☐Spouse ☐Child ☐Other

Subscriber Name: _____ Subscriber ID #: _____

Employer: _____ Group #: _____

Insurance Company: _____

Address 1: _____

Address 2: _____

City: _____ State: _____ Zip: _____

Phone: _____

Medical History

First Name:_____**Last Name:**_____**Birth Date**:_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you receive. Thank you for answering the following questions.

Are you under a physician's care now?	☐Yes ☐No	If yes, explain:_____
Have you been hospitalized or had a major operation?	☐Yes ☐No	If yes, explain:_____
Have you even had a serious head or neck injury?	☐Yes ☐No	If yes, explain:_____
Are you taking any medications, pills, or drugs?	☐Yes ☐No	If yes, explain:_____
Do you take, or have taken, Phen-Fen or Redux?	☐Yes ☐No	If yes, explain:_____
Are you on a special diet?	☐Yes ☐No	If yes, explain:_____
Do you use tobacco?	☐Yes ☐No	If yes, explain:_____
Do you use controlled substances?	☐Yes ☐No	If yes, explain:_____
Do you have frequent headaches?	☐Yes ☐No	If yes, explain:_____
Do you have sensitive teeth?	☐Yes ☐No	If yes, explain:_____

Are you allergic to any of the following?

☐Aspirin ☐Penicillin ☐Codeine ☐Acrylic ☐Metals ☐Latex ☐Local Anesthetics

☐Other Please explain:_____

Women - Are You:

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

Check any that apply

☐AIDS/HIV Positive	☐Alzheimer's Disease	☐Anaphylaxis	☐Anemia
☐Angina	☐Arthritis/Gout	☐Artificial Heart Valve	☐Artificial Joint
☐Asthma	☐Blood Disease	☐Blood Transfusion	☐Breathing Problems
☐Bruise Easily	☐Cancer	☐Chemotherapy	☐Chest Pains
☐Cold Sores/Fever Blisters	☐Congenital Heart Disease	☐Convulsions	☐Convulsions
☐Cortisone Medicine	☐Diabetes	☐Drug Addiction	☐Easily Winded
☐Emphysema	☐Epilepsy/Seizures	☐Excessive Bleeding	☐Excessive Thirst
☐Fainting or Dizziness	☐Frequent Cough	☐Frequent Diarrhea	☐Facial Pain
☐Genital Herpes	☐Glaucoma	☐Hay Fever	☐Heart Attack/Failure
☐Heart Murmur	☐Heart Pacemaker	☐Heart Trouble/Disease	☐Hemophilia
☐Hepatitis A	☐Hepatitis B or C	☐Herpes	☐High Blood Pressure
☐Hives or Rash	☐Hypoglycemia	☐Irregular Heartbeat	☐Kidney Problems
☐Leukemia	☐Liver Disease	☐Low Blood Disease	☐Lung Disease
☐Mitral Valve Prolapse	☐Pain in Jaw Joints	☐Parathyroid Disease	☐Psychiatric Care
☐Radiation treatment	☐Recent Weight Loss	☐Renal Dialysis	☐Rheumatic Fever
☐Rheumatism	☐Scarlet Fever	☐Shingles	☐Sickle Cell Disease
☐Sinus Trouble	☐Spina Bifida	☐Stomach/Intestinal Disease	☐Stroke
☐Swelling in Limbs	☐Thyroid Disease	☐Tonsillitis	☐Tuberculosis
☐Tumors or Growths	☐Ulcers	☐Venereal Disease	☐Yellow Jaundice

Have you ever had a serious illness not listed above? If yes, explain: _____

_____

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 or Patient's Guardian: _____Date:_____

Dental Health History

What is your primary reason for being here today? _____

_____

When was your last dental visit? _____ What was done? _____

Name and city of former dentist _____

Whom may we thank for referring you to Anderson Dental Associates? _____

Describe in your own words, how we may help you:_____

Unpleasant experience with dentist(s) in past (describe) _____

□Yes□No Have you been under regular care by a dentist?

□Yes□No Are your teeth sensitive to sweets?

□Yes□No Are your teeth sensitive to temperature?

□Yes□No Do you have any loose teeth?

□Yes□No Do any of your teeth ache?

□Yes□No Do your gums bleed or have pain?

□Yes□No Do your gums feel tender or swollen?

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

□Yes□No Do you notice popping in your jaw?

□Yes□No Are you tense during dental visits?

□Yes□No Are you happy with the appearance of your teeth?

□Yes□No Would you be interested in learning more about oral sedation?

□Yes□No Would you be interested in learning more about the treatment for snoring or sleep apnea?

Smile Analysis

□ I wish my teeth were whiter

□ I grind my teeth to where the biting edges are chipped

□ I wish my teeth were straighter

□ When I smile, I show too much gum

□ I think my smile shows too much space between my teeth

□ I have gray, black, silver fillings that show when I smile

□ I am sometimes hesitant to smile

□ My old crowns have dark edges and don't look natural

□ Some of my teeth appear short and fat OR too small or too large

□ I am concerned about the cost of enhancing my smile

How do you rate your smile on a scale of 1-10, with 10 being the best smile? _____

□ I would like to learn more about enhancing my own smile with cosmetic dentistry

Consent for Procedure

I certify that all of the above medical and dental information is true to my knowledge and that I have not omitted any pertinent information. I consent to the performing of dental or oral surgery procedures agreed to be necessary and advisable, including the use of local anesthetic and nitrous oxide as indicated. I understand that I will be informed of any treatment changes as they occur. I wish to assign any benefits under my dental insurance policy to Anderson Dental Associates if applicable. I will assume responsibility for all fees associated with any procedures and costs incurred from my dental treatment. Further, I consent to allow my clinical photographs to be used by the doctors in an educational environment.

Patient's (Parent's) signature _____ Date _____

Doctor's signature: _____ Date _____

ANDERSON
Dental Associates
FAMILY & COSMETIC DENTISTRY

PHOTOGRAPHY CONSENT

Patient Name:_____

I hereby authorize Anderson Dental Associates and staff to take photographs and/or videos of my face, jaws, mouth, and teeth. I understand that the photographs and/or videos will be used as a record of my care, and may be used for educational purposes in study club meetings, lectures, seminars, demonstrations, and professional publications (journals, magazines). I further understand that if the photographs and/or videos are used in any publication or as a part of a demonstration, my name or other identifying information will be kept confidential.

I do not expect compensation, financial or otherwise, for the use of these photographs.

_____ _____

Patient's (or Legal Guardian's) Signature Date

Anderson Dental Associates
1431 Howell Branch Road, Winter Park, FL 32789
407-644-5454
www.AndersonDentalAssociates.com

ANDERSON
Dental Associates
FAMILY & COSMETIC DENTISTRY

No Show / Late Cancellation Policy

This policy has been established to help us serve you better.

At Anderson Dental Associates we do our very best to exceed your expectations. We take pride in our clinical excellence and superior customer service.

A **fee of $25.00** will be added to your account for No Show/Late Cancellations. To cancel your appointment please call at least **24 hours** prior to your appointment. To avoid a No Show/Late Cancellation fee please call during normal business hours.

We understand that situations such as medical emergencies occasionally arise when an appointment cannot be kept and adequate notice is not possible. These situations will be considered on a case by case basis.

We appreciate your consideration.

_____ _____

Patient's Signature or Legal Guardian Date

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FAMILY & COSMETIC DENTISTRY

Patient Acknowledgement and Consent Form

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with one of HIPAA's requirements we are giving you a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices.

From time to time it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another dentist or other health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

Please sign this form below to acknowledge that you have either received or reviewed a copy of our Notice of Privacy Practices and to consent to our disclosures of your information that we deem necessary in order to provide your with proper treatment.

I acknowledge that I have either received or reviewed a copy of the Notice of Privacy Practices.

I consent to your disclosures of my information, which you deem are necessary in connection with my treatment. I understand that such disclosures may not be of the type listed above.

_____	_____	_____
Patient Signature	**Patient Name (please print)**	**Date**

I am also signing for my minor children:_____

(please print names)

_____

(please print names)

Release of Information

I also give consent for my treatment to be discussed with the following individuals: (e.g. spouse, parent, adult child, caregiver)

_____	_____
Name	**Relationship**
_____	_____
Name	**Relationship**
_____	_____
Name	**Relationship**
_____	_____
Name	**Relationship**

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Anderson Dental Associates
Notice of Privacy Practices

- This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.
- At Anderson Dental Associates we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to allow the terms of this notice.
- The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in you care.
- We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.
- We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.
- We may share your medical information with your business associates, such as a billing service. We have a written contract with each business associate that request them to protect your privacy.
- We may use your information to contact you. For example, we may send newsletters or other information or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.
- In an emergency, we may disclose your health information to a family member or another person responsible for your care.
- We may release some or all of your health information when required by law.
- If this practice is sold, your information will become the property of the new owner.
- Except as described above, this practice will not use or disclose your health information without your prior written authorization.
- You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.
- You have the right to know of any used or disclosures we make with your health information beyond that above normal uses.
- As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.
- You have the right to transfer copies of your health information to another practice. We will mail your files for you.
- You have the right to see and receive a copy of your health information. With a few exception. Give us a written request regarding the information you want to see. If you also want a copy of your records we may charge you a reasonable fee for the copies.
- You have the right to request an amendment or change to your health information, give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove or alter earlier documents, but will add new information.
- You have the right to receive a copy of this notice.
- If we change any of the details of this notice, we will notify you of the change at your next appointment after the effective date of the change.
- We reserve the right to have your medical records and files reviewed by our corporation’s attorney as part of our medical quality assurance.
- You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, SW, Room 509-F, Washington, DC 20201. You will not be retaliated against for filing a complaint.
- However, before filing a complaint, or for more information, or assistance regarding your health information privacy, please contact our office at (407)644-5454.

This notice goes into effect as of April 14, 2003