PATIENT REGISTRATION FORM

PATIENT INFORMATION

Today's Date _____

Patient's Name _____
Last Name First Name Middle Initial

DOB _____ Age _____ Sex □ M □ F

Patient SS# _____

Patient Driver License # _____
If patient is minor we need:
Guardian's Name and DOB _____

Home Address

_____
Street Name & Number City State Zip

E-mail _____

Home Phone _____

Work Phone _____

Cell Phone _____
Please check one: □ Married □ Widowed □ Single □ Minor
□ Separated □ Divorced □ Partnered for _____ years

Patient's Employer _____

Occupation _____

Emergency Contact
Name _____

Relationship _____

Phone _____

Reference
How did you hear about our office?

_____
If you were referred by a friend, whom may we thank for referring you?

_____

Reason for Today's Visit

_____

DENTAL INSURANCE INFORMATION

Person responsible for this account _____

Relationship to Patient _____

Insurance Co. _____

Group # _____
Is Patient covered by **additional Insurance**? □ Yes □ No

Subscriber's Name _____

DOB _____ SS# _____

Relationship to Patient _____

Subscriber's employer _____

Insurance Co. _____

Group # _____

Assignment And Release
I certify that I, and/or my dependent(s) have insurance coverage with _____
name of insurance company(ies)
and assign directly to Dr. Cheneweth all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above –named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Patient Signature (or Parent, Guardian or Personal Representative)

_____
Print name of Patient, Parent, Guardian or personal Representative

Date _____

Relationship to Patient _____

DENTAL HISTORY

Name of Previous Dentist _____ City/State _____ Phone # _____

Date of last dental visit _____ Reason _____ Date of last complete X-rays _____

Why did you leave your previous dentist? _____

Please check any of the following that apply to you:
□ Bad breath
□ Lip or cheek biting
□ Teeth or fillings breaking
□ Mouth breathing
□ Headaches, ear aches, jaw pain
□ Sensitivity when biting

□ Burning sensation on tongue
□ Clicking or popping jaw
□ Periodontal treatment
□ Dry mouth
□ Loose, tipped or shifting teeth
□ Mouth ulcers, blisters or sores
□ Bleeding, swollen gums

□ Fingernail biting
□ Sensitivity (hot, cold, sweet)
Where? □ UR □ LR □ UL □ LL
□ Grinding teeth
□ Smoking or chewing tobacco
How much? _____(#packs/day)
For how long? _____(years)

If you could change your smile, you would:

- ☐ Make your teeth whiter
- ☐ Make your teeth straighter
- ☐ Close spaces
- ☐ Replace metal filling with tooth colored restorations
- ☐ Repair chipped teeth
- ☐ Replace missing teeth
- ☐ Replace old crowns that don't match
- ☐ Have a smile makeover

On a scale of 1-10 with 10 being the highest rating:

How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

Do you have or had any of the following?

☐ Dentures ☐ Partial dentures
☐ Braces ☐ Gum treatments

What is the most important thing to you and your dental visit today?

_____

What is the most important thing to your about your future smile and dental health?

_____

MEDICAL HISTORY

Physician's Name _____ Phone # _____ Date of last visit _____

Have you ever used bisphosphonate medication? Common brand names are ☐ Fosamax ☐ Actonel ☐ Atelvia ☐ Didronel ☐ Boniva

Have you ever taken any of the group collectively referred to as "Fen-phen?" These include combinations of Ionimin, Adipex Fastin (brand names of phentermine), Pondimin, (fenfluramine) and Redux (dexfenfluramine).

Please check any of the following that apply to you:

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Congenital Heart Lesions
- ☐ Cortisone Treatments
- ☐ Cough, Persistent or bloody
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Emphysema
- ☐ Excessive Bleeding with extractions or surgery
- ☐ Epilepsy
- ☐ Fainting or dizziness
- ☐ Glaucoma
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hepatitis Type (A, B or C ____)
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Nervousness / Depression
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Stomach Problems
- ☐ Sinus Trouble
- ☐ Skin Rash
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis (TB)
- ☐ Tumor or growth on head or neck
- ☐ Ulcer
- ☐ Other (please list):

_____

_____

Women: ☐ Pregnant (mons: ☐ 0-3, ☐ 3-6, ☐ 6-9) ☐ Due Date _____ ☐ Are you breast-feeding ☐ Taking birth control

What medications are you currently taking? List any medications you are currently taking and correlating diagnosis:

_____

_____

Pharmacy Name _____ Phone _____

Are you under a physician's care? For what?

_____

Do you have an allergy to any of the following?

- ☐ Aspirin
- ☐ Barbiturates (sleeping pills)
- ☐ Codeine
- ☐ Erythromycin
- ☐ Iodine
- ☐ Latex
- ☐ Clindamycin
- ☐ Local Anesthetic
- ☐ Nitrous oxide
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other

_____

_____

DENTAL TREATMENT CONSENT FORM

Please read, initial the items, and sign at the bottom of form.

Patient Name: _____

1. DIAGNOSTIC AND PREVENTIVE
I understand that I am having the following work done:
X-rays _____ Cleaning _____ Scaling _____ Fluoride _____
Sealants _____ (Initials_____)

2. DRUGS, MEDICATIONS AND LOCAL ANESTHETICS
I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). I also understand there are risks of local anesthesia that may affect my body such as dizziness, nausea, vomiting, accelerated/slow heart rate, or various types of allergic reactions. It may also cause injury to nerves that can result in pain, tingling, or numbness that may persist for several weeks, months, or rarely, be permanent. I have informed my dentist of my complete medical history, including any recent surgeries, changes in my medical history, and any known allergies. (Initials_____)

3. CHANGES IN TREATMENT PLAN
I understand that during treatment it may be necessary to change and/or add procedures because of conditions found while working on the teeth that were not discovered during examination. Upon my consent, I give my permission to the Dentist to make any/all changes and additions as necessary. (Initials_____)

4. REMOVAL OF TEETH
Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth _____.
I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (Paresthesia) that can last for an indefinite period of time (days or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.
(Initials_____)

5. CROWNS (CAPS) AND BRIDGES
I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size and color) will be before cementation. Once cemented, I understand that any changes in shape, fit, size, or color will incur an additional charge. (Initials_____)

6. DENTURES, COMPLETE OR PARTIAL
I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing these appliances have been explained to me, including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new dentures (including shape, fit, size, placement, and color) will be the "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee.
(Initials_____)

7. ENDODONTIC TREATMENT (ROOT CANAL)
I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment. I understand that root canals can fail and may require additional treatment or I may end up having the tooth extracted. I also understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy). (Initials_____)

8. PERIODONTAL LOSS (TISSUE & BONE)
I understand that I have a serious condition, causing gum and bone infection that can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition. (Initials_____)

9. FILLINGS
I understand that I may experience hot and cold sensitivity, pain or discomfort following routine restorative procedures and that this is usually temporary and should settle without further treatment. If in the event that my condition does not get any better, I understand that I may need further dental treatment, the most common being root canal therapy, resulting in additional costs. (Initials_____)

10. DENTURES
I understand the wearing of dentures is difficult. Sore spots altered speech and difficulty in eating are common problems. Immediate dentures (placement of dentures immediately after extractions) may be painful. Immediate dentures may require considerable adjusting and several relines. A permanent reline will be needed later. This is not included in the denture fee. I understand that it is my responsibility to return for delivery of the dentures. I understand that failure to keep my delivery appointment may result in poorly fixed dentures. If a remake is required due to my delays of more than 30 days there will be additional charges. (Initials_____)

Signature of Patient or Legal Guardian _____ Date_____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES
CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

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. You may obtain a copy of our Notice of Privacy Practices, including any revision of our Notice, at any time by contacting this office. 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 out 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.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation. 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.

_____
Patient Name

_____ _____
Patient / Responsible Party 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).

FOR OFFICEIAL USE ONLY

REVOCATION OF CONSENT

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 have revoked my Consent.

_____ _____
Patient / Responsible Party Signature Date

PATIENT – DOCTOR AGREEMENTS

We would like to take a moment to welcome you to our office and to assure you that you will be receiving the very best care available for your condition. The purpose of this agreement is to allow us to more completely serve you and for you to get needed treatment on time. It is our experience that those patients who follow through with these agreements get the best results.

MISSING OR CHANGING APPOINTMENTMENTS:

The doctor will set up a specific course of treatment for you. A certain amount of time is reserved for you pre your request based on your treatment length. Thus in order to get the results we both desire and be respectful of the dental needs of other patients, we request notice of at least 24 hours in advance for cancellation of appointments. If you do not reach the receptionist you may leave a detailed message on the voice mail. If appropriate notice is not given, it will be considered as a "no-show" and a certain amount will be deducted from your account. After certain number of "no-show" no further appointment can be made and you would be considered as a "walk-in only patient", who can only be seen by the doctor based on the availability of that day. We take our patient care very seriously and will work hard to achieve your treatment goals. SCHEDULE YOUR LIFE AROUND YOUR HEALTH, NOT YOUR HEALTH AROUND YOUR LIFE.

PATIENT PAYMENT:

We will expect you to honor the financial agreement you make with our office. Payments / co-payments are due at the time the service is provided. Upon your final visit your account must be paid in full or a current written financial agreement must be made n advance of your departure. We accept cash and all major credit cards. We also offer CARE˙CREDIT as an option. If the current arrangement becomes inconvenient for you, please see our front desk assistant so that other arrangements can be made in advance.

REFUNDS FOR UNFINISHED TREATMENT:

Please understand that if a patient decides to discontinue treatment after it has been started, a full refund will not be given. Individual circumstances may be discussed with the dentist.

COMMUNICATION:

Please communicate to us any upsetting matters. We are here to serve you. Your criticism will help us to help you as well as others.

Thank you, we appreciate your cooperation!

I, (print) _____ understand the above policy and agree to abide by it.

Signature _____ Date _____