

# REGISTRATION

Patient's Name: \_\_\_\_\_ Date \_\_\_\_\_ Date of Birth \_\_\_\_\_  
(Last) (First) (MI)

If Child: Parent's Name: \_\_\_\_\_  
(Last) (First) (MI)

How do you wish to be addressed \_\_\_\_\_

- Male  Female  
 Single  Married  Divorced  Widowed

Residence – Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Telephone - Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_  
Email Address \_\_\_\_\_

Patient/Parent Employed by \_\_\_\_\_ Present Position \_\_\_\_\_

Patient Social Security No. \_\_\_\_\_ Spouse/Parent SSN \_\_\_\_\_

Spouse/Parent Name \_\_\_\_\_ Spouse Employed by \_\_\_\_\_

Who is responsible for this account \_\_\_\_\_  
Method of payment:  Insurance  Credit Card  Cash  Check

Purpose of initial visit \_\_\_\_\_

Whom may we thank for this referral \_\_\_\_\_

Name and number of someone to notify in case of emergency \_\_\_\_\_

\*\*\* Patients with insurance please bring insurance card to appointment\*\*\*

## RELEASE:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payor.

I have thoroughly read and understand the Financial Arrangement brochure.

I understand that any account that goes 90 days past due will be subject to a 1.5% finance charge per month.

I understand that a \$25 cancellation fee will be charged for any appointment cancelled with less than 24 hours notice.

I attest to the accuracy of the information on this page.

Patient's or Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

# DENTAL HISTORY

PATIENT'S NAME \_\_\_\_\_  
Last First Initial Date of Birth

1. Purpose of initial visit \_\_\_\_\_  
\_\_\_\_\_
2. Are you aware of a problem? \_\_\_\_\_
3. How long since your last dental visit? \_\_\_\_\_
4. What was done at that time? \_\_\_\_\_
5. Previous dentist's name \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_
6. When was the last time your teeth were cleaned? \_\_\_\_\_
7. Have you made regular visits? YES NO How often? \_\_\_\_\_
8. Were dental x-rays taken? YES NO
9. Have you lost any teeth or have any teeth been removed? YES NO  
Why? \_\_\_\_\_
10. Have they been replaced? YES NO
11. How have they been replaced?
  - a. Fixed bridge \_\_\_\_\_ Age \_\_\_\_\_
  - b. Removable bridge \_\_\_\_\_ Age \_\_\_\_\_
  - c. Denture \_\_\_\_\_ Age \_\_\_\_\_
12. Are you unhappy with the replacement? YES NO  
If yes, explain \_\_\_\_\_
13. Would you like to know about permanent replacements? YES NO
14. Have you ever had any problems or complications with previous dental treatment? YES NO  
If yes, explain \_\_\_\_\_
15. Do you clench or grind your teeth? YES NO
16. Does your jaw click or pop? YES NO
17. Have you experienced any pain or soreness in the muscles of your face or around your ear? YES NO
18. Do you have frequent headaches, neckaches or shoulder aches? YES NO
19. Does food get caught in your teeth? YES NO
20. Are any of your teeth sensitive to: Hot? \_\_\_\_\_ Cold? \_\_\_\_\_ Sweets? \_\_\_\_\_ Pressure? \_\_\_\_\_
21. Do your gums bleed or hurt? YES NO  
When? \_\_\_\_\_
22. How often do you brush your teeth? \_\_\_\_\_ When? \_\_\_\_\_
23. Do you use dental floss? YES NO How often? \_\_\_\_\_
24. Are any of your teeth loose, tipped, shifted or chipped? YES NO
25. Are you unhappy with the appearance of your teeth? YES NO
26. How do you feel about your teeth in general? \_\_\_\_\_  
\_\_\_\_\_
27. Do you feel your breath is offensive at times? YES NO
28. Have you ever had gum treatment or surgery? YES NO WHAT? \_\_\_\_\_  
Where? \_\_\_\_\_ When? \_\_\_\_\_
29. Have you had any orthodontic work? YES NO
30. Have you had any unpleasant dental experiences or is there anything about dentistry that you  
strongly dislike? \_\_\_\_\_
31. Do you have any questions or concerns? YES NO

COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

DENTIST SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

## PATIENT MEDICAL HISTORY

Patient's Name:

For Office Use Only

ID

Address:

Today's Date:

Date of Last Visit:

Date of Med. History:

City

State

Zip

Email:

Home Phone:

Work Phone:

Birth Date:

Social Security No.:

Marital Status:

Primary Dental Guarantor:

Home Phone:

Work Phone:

Secondary Dental Guarantor:




Physician Name:

Physician Phone:

Pharmacy:

Pharmacy Phone:

For Office Use Only

Medical Alerts:

Sex:

If female, Please answer the following:

Y	N	
<input type="checkbox"/>	<input type="checkbox"/>	Are you taking Birth Control Pills?
<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant? If yes, # of weeks
<input type="checkbox"/>	<input type="checkbox"/>	Are you nursing?

Please answer the following:

Y	N			
<input type="checkbox"/>	<input type="checkbox"/>	Do you smoke/use tobacco?	Height	<input style="width: 40px;" type="text"/>
For Office Use Only			Weight	<input style="width: 40px;" type="text"/>
		BP	<input style="width: 40px;" type="text"/>	Heart Rate
			<input style="width: 40px;" type="text"/>	<input style="width: 40px;" type="text"/>

Y	N	<u>Conditions</u>	Y	N	<u>Conditions</u>	Y	N	<u>Conditions</u>
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems
<input type="checkbox"/>	<input type="checkbox"/>	Alcohol Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers
<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Yellow Jaundice
<input type="checkbox"/>	<input type="checkbox"/>	Angina Pectoris	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever
<input type="checkbox"/>	<input type="checkbox"/>	Articial Bones	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure			
<input type="checkbox"/>	<input type="checkbox"/>	Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	HIV+ AIDS			
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems			
<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease			
<input type="checkbox"/>	<input type="checkbox"/>	Cancer-Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure			
<input type="checkbox"/>	<input type="checkbox"/>	Colitis	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse			
<input type="checkbox"/>	<input type="checkbox"/>	Congenital Heart Defect	<input type="checkbox"/>	<input type="checkbox"/>	Pace Maker			
<input type="checkbox"/>	<input type="checkbox"/>	Cosmetic Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Pneumocystitis			
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatic Problems			
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Breathing	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy			
<input type="checkbox"/>	<input type="checkbox"/>	Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever			
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Seizures			
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Shingles			
<input type="checkbox"/>	<input type="checkbox"/>	Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease			
<input type="checkbox"/>	<input type="checkbox"/>	Fever Blisters	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems			
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Stroke			

Y	N	<u>Allergies</u>
<input type="checkbox"/>	<input type="checkbox"/>	Aspirin
<input type="checkbox"/>	<input type="checkbox"/>	Codeine
<input type="checkbox"/>	<input type="checkbox"/>	Dental Anesthetics
<input type="checkbox"/>	<input type="checkbox"/>	Jewelry
<input type="checkbox"/>	<input type="checkbox"/>	Latex
<input type="checkbox"/>	<input type="checkbox"/>	Metals
<input type="checkbox"/>	<input type="checkbox"/>	Penicillin
<input type="checkbox"/>	<input type="checkbox"/>	Tetracycline
Other		
_____		
_____		

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**Medications:** (Dose and Timing)

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Y N

Is there any disease, condition, or problem that you think this office should know about that is not covered above?  
If yes, please describe below...

Notes:

Would you like to speak to the doctor privately about any problem?

Y N

**Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

(If Under 18, Parent or Guardian Signature Required)

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## NOTICE OF PRIVACY PRACTICES

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THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

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### OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain. Including health information we created or received before we made the changes. Before we make a significant change in our privacy practices we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

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### USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization we cannot use or disclose your health information for any reason except those described in this Notice.

**To Your Family and Friends:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

**Persons Involved In Care:** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

**Marketing Health-Related Services:** We will not use your health information for marketing communications without your written authorization.

**Required by Law:** We may use or disclose your health information when we are required to do so by law.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, another national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

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#### PATIENT RIGHTS

**Access:** You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless, we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$0.60 for each page. \$25.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in the format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

**Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency.)

**Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

**Amendment:** You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

**Electronic:** If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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#### QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with us or with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Dr. Kenneth Barrack  
Telephone: 843-849-9044  
E-Mail: [CCRDentistry@aol.com](mailto:CCRDentistry@aol.com)  
Address: 966-I Houston Northcutt Blvd.  
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Fax: 843-849-7493