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 probems 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 requent headaches, nechaches 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 CERTIFIY 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	
☐	☐	Are you taking Birth Control Pills?
☐	☐	Are you pregnant? If yes, # of weeks
☐	☐	Are you nursing?

Please answer the following:

Y	N	
☐	☐	Do you smoke/use tobacco?

For Office Use Only
BP ☐ Heart Rate ☐

Height ☐
Weight ☐

Y	N	Conditions
☐	☐	Abnormal Bleeding
☐	☐	Alcohol Abuse
☐	☐	Allergies
☐	☐	Anemia
☐	☐	Angina Pectoris
☐	☐	Arthritis
☐	☐	Articial Bones
☐	☐	Artificial Heart Valve
☐	☐	Asthma
☐	☐	Blood Transfusion
☐	☐	Cancer-Chemotherapy
☐	☐	Colitis
☐	☐	Congenital Heart Defect
☐	☐	Cosmetic Surgery
☐	☐	Diabetes
☐	☐	Difficulty Breathing
☐	☐	Drug Abuse
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Fainting Spells
☐	☐	Fever Blisters
☐	☐	Frequent Headaches

Y	N	Conditions
☐	☐	Glaucoma
☐	☐	Heart Attack
☐	☐	Heart Surgery
☐	☐	Hemophilia
☐	☐	Hepatitis A
☐	☐	Hepatitis B
☐	☐	High Blood Pressure
☐	☐	HIV+ AIDS
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	Low Blood Pressure
☐	☐	Mitral Valve Prolapse
☐	☐	Pace Maker
☐	☐	Pneumocystitis
☐	☐	Psyciatirc Problems
☐	☐	Radiation Therapy
☐	☐	Rheumatic Fever
☐	☐	Seizures
☐	☐	Shingles
☐	☐	Sickle Cell Disease
☐	☐	Sinus Problems
☐	☐	Stroke

Y	N	Conditions
☐	☐	Thyroid Problems
☐	☐	Tuberculosis
☐	☐	Ulcers
☐	☐	Yellow Jaundice
☐	☐	Venereal Disease
☐	☐	Hay Fever

Y	N	**Allergies**
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline

Other
_____
_____

>>>>>

Medications: (Dose and Timing)

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)

NOTICE OF PRIVACY PRACTICES

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.

OUR LEGAL DUTY

We re 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 or privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We used 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 proved 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).

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.

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. Mayur Patel
Telephone: 843-849-9044 Fax: 843-849-7493
E-Mail: info@ccrdonline.com
Address: 682 Johnnie Dodds Blvd. Suite 102
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