PATIENT REGISTRATION AND MEDICAL HISTORY

Date _____ (PLEASE PRINT) Home Phone _____

Last Name First name Initial Preferred Name

Street Address _____ City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Employed By _____ Occupation _____

Business Address _____ Business Phone _____

Spouse Name _____ Cell Phone _____

Spouse Employed By _____ Occupation _____

Business Address _____ Business Phone _____

Who is responsible for this account? _____ Relationship to Patient _____

Social Security # _____ Spouse's Social Security # _____

Name of Dental Insurance Company _____ Group Number _____

In case of emergency, who should be notified? _____ Phone _____

Whom may we thank for referring you? _____

MEDICAL HISTORY

Physician's Name _____ Date of Last Physical

Former Dentist's Name _____ Date of Last Dental Visit _____ Date of Last Dental X-Rays _____

Have you ever had any of the following? (Check boxes that apply):

- ☐ Heart Problems
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Circulatory Problems
- ☐ Nervous Problems
- ☐ Radiation Treatment
- ☐ Artificial Heat Valves or joints (Hips & Knees)
- ☐ Back Problems
- ☐ Diabetes
- ☐ Respiratory Disease
- ☐ Epilepsy
- ☐ Headaches
- ☐ Hepatitis, Jaundice or Liver Disease
- ☐ Cancer
- ☐ Psychiatric Care
- ☐ Chronic Diarrhea
- ☐ Allergies to Anesthetics
- ☐ Allergies to Medicines or Drugs
- ☐ General Allergies
- ☐ Blood Disease
- ☐ Arthritis
- ☐ Asthma
- ☐ Swollen Neck Glands
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ "A.I.D.S." or Other Immunosuppressive Disorders
- ☐ Stroke
- ☐ Ulcer
- ☐ Venereal Disease
- ☐ Chemical Dependency
- ☐ Hemophilia

Do you have any drug allergies or have you ever had an adverse reaction to any medication? _____ If so, what? _____

Have you ever responded adversely to medical or dental treatment? _____

Are you taking any medication at this time? _____ If so, what? _____

Are you under the care of a physician? ☐ Yes ☐ No

For what conditions? _____

(Women) Do you suspect that you are pregnant? ☐ Yes ☐ No Are your taking birth control pills? ☐ Yes ☐ No

is there anything else we should know about your medical history? _____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment billing, and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any error or omissions that I may have made in the completion of this form

Reviewed by: _____

Date: _____

Date _____ Signature _____

Have there been any changes in your health or new medication since your last dental appointment? ☐ No ☐ Yes

Reviewed by: _____

Date: _____

Signature _____ Date _____

Have there been any changes in your health or new medication since your last dental appointment? ☐ No ☐ Yes

Reviewed by: _____

Date: _____

Signature _____ Date

JAMIE L. SHORE, DDS

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient #: _____ Social Security #: _____

SECTION B: 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. A copy of our Notice accompanies this Consent. 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 our 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.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: _____

Telephone: _____ Fax: _____

E-mail: _____

Address: _____

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

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.

JAMIE L. SHORE, DDS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communications barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

Other (Please Specify)

_____

_____

_____

CANCELLATION POLICY

In order to keep our fees as low as possible, it is very important that you, our patient, keep all appointments that you have made. Missed or broken appointments increase the expense of treatment for both patient and doctor. Your appointment has been scheduled so that we have proper time to treat you and to address your needs.

If you are unable to keep your appointment, it is necessary that you notify our office at least 24 hours (one working day) before your scheduled appointment time. For appointments greater than one hour in length, 48 hours' notice is required. If you do not keep your appointment or fail to notify us properly in advance, a charge of $30.00 per half hour will be made, which must be paid before your next appointment.

For hygiene appointments, a charge of $20.00 per half hour will be incurred.

Thank you for helping us practice economically and efficiently.

_____

SIGNATURE

JAMIE L SHORE, D.D.S.
FEE/ INSURANCE ESTIMATE

If you have insurance please remember that as a courtesy to you we are verifying and filing the insurance on your behalf. We CANNOT guarantee that the information provided is correct. The calculations below are ONLY estimates and do not constitute a contract for services provided. It is YOUR responsibility to review the Explanation of Benefits when you receive it from your insurance provider.

ANY UNPAID OR RESIDUAL BALANCE REMAINS YOUR RESPONSIBILITY.

___ THIS HAS BEEN EXPLAINED TO ME AND I UNDERSTAND THE ABOVE INFORMATION.

PRINT NAME _____

SIGNATURE OF PARENT OR GUARDIAN _____

DATE _____