David C. Henderson D.M.D General Dentistry, P.A.

Registration Form

(Please Print)

PATIENT INFORMATION

❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms. ❑ Dr. Name: _____ M.I.____ Last Name: _____

Preferred Name: _____ Former name:_____ Marital status (circle one) Single / Mar / Div / Sep / Wid

Sex: ❑ M ❑ F Birth date: ____/____/____ DL#_____ Social Security no.: _____- _____- _____

Home Phone no: (____) _____ - _____ **Cell Phone:** (____)_____ -_____ **Email Address**:_____
Would you like text reminders: (circle one) yes no **Email needed for reminders, birthdays & news**

Address:_____

City:_____**State:**_____ **ZIP Code:**_____

Occupation: _____ Employer: _____Employer phone no.: (____)____ -_____

How did you find out about us? (please check one box): ❑ Doctor ❑ Family/Friend ❑ Website ❑ Yellow Pages ❑ Newspaper ❑ Radio Name of person who referred you:_____
Other family members seen here: _____

Name of local friend or relative (**NOT living at same address**): _____ Relationship to patient:_____

Home phone no.: (____)_____-_____ Work phone no.: (_____)_____-_____ Cell phone no.: (_____)_____ -_____

PARENT/GUARDIAN INFORMATION (IF SELF, SKIP TO NEXT SECTION)

Name:_____ Birth date:____/____ /_____ Social Security no.: _____-_____-_____

Is this person a patient here? ❑ Yes ❑ No Relationship: ❑ Father ❑ Mother ❑ Legal Guardian Home phone no.: (_____)_____-_____

Address: _____ Cell Phone: (_____)_____-_____

Occupation: _____ Employer: _____ Employer phone no. :(_____)_____-_____

DENTAL INSURANCE INFORMATION

Primary Dental Insurance Company	Secondary Dental Insurance Company
Employer_____	Employer_____
Business Address_____	Business Address_____
Bus Tel_____ Plan_____	Bus Tel_____ Plan_____
Ins Co Name_____	Ins Co Name_____
Address_____	Address_____
Group#_____Group Name_____	Group#_____Group Name_____
Insured Party:_____Relation:_____	Insured Party:_____Relation:_____
Sex ❑ M ❑ F Birth Date _____ SSN_____	Sex ❑ M ❑ F Birth Date _____ SSN_____
ID#_____	ID#_____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me. I understand that I am financially responsible for any balance. I understand that that I will be responsible for any and all fees or cost incurred included legal or attorney fees, necessary to collect for services/charges provided by this office. I also authorize Henderson Dental or said insurance company to release any information required to process my claim and to release any information to secure payment by use of collection agency, court or attorney. In addition, I give permission to have my records and/or x-rays shared with my medical physician or other specialist as needed.
Henderson Dental has my permission to obtain medical information that pertains to my dental treatment from my physician(s).

Patient **OR** Parent/Guardian Signature _____ Today's Date_____

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HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES AND CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgment & authorization/ In refusing we may not be allowed to process your insurance claims.

Date:_____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR/FACILITIES IN THE FUTURE.

_____ _____

Please **print** name of patient Please **sign** for Patient/Guardian of Patient

_____ _____

Legal Representative/Guardian Relationship of Legal Representative/Guardian

Your comments regarding Acknowledgements or Consents: _____

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

☐ First Name Only ☐ Proper Surname ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

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I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation ☐ Text Message to my Cell Phone ☐ Home Phone Confirmation
☐ Email Confirmation ☐ Work Phone Confirmation ☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation ☐ Text Message to my Cell Phone ☐ Home Phone Confirmation
☐ Email Confirmation ☐ Work Phone Confirmation ☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALT INFO** on behalf of this Healthcare Facility via:

☐ Phone Message ☐ Text Message ☐ Email ☐ **Any of the Above** ☐ **None of the above** (opt out)In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

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HEALTH HISTORY

To our patients: Although dentists primarily treat the area in & around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication that you may be taking could have an important interrelationship with the care that you will be receiving. Thank you for answering the following questions. Your answers are for our records & will be considered confidential.

Patient's name:_____ Birthdate:_____

DENTAL HISTORY

Reason for Today's visit:_____

Date of last dental care:_____ Date of last dental x-rays:_____

Have you ever used nitrous oxide (happy gas) before? .....❑ Yes ❑ No Would you like to use nitrous oxide (happy gas)? ..... ❑Yes ❑ No

Have you had any serious problems with previous dental treatment?..... ❑ Yes ❑ No Do you have a removable dental appliance? ..... ❑Yes ❑No

Have you had excessive bleeding following tooth extractions, surgery, or injury?..... ❑ Yes ❑ No

Name of former dentist and address: _____

MEDICAL HISTORY

Physician's Name and phone #:_____ Date of last visit:_____

Have you had any serious illnesses or operations in the past 5 years? ..... ❑Yes ❑No
If yes, describe:_____
Do you have unhealed/recurrent or inflamed areas, growths or sore spots in or around your mouth? .....❑Yes ❑No
If yes, describe:_____
Do you have a prosthetic joint/implant? .....❑Yes ❑No
If yes, describe:_____
Have you had a heart valve replacement or vascular graft? ..... ❑Yes ❑No

HAVE YOU HAD OR DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING CONDITIONS:

❑Yes ❑No Anemia	❑Yes ❑No Cough, Persistent	❑Yes ❑No High Blood Pressure	❑Yes ❑No Seizures
❑Yes ❑No Arthritis, Rheumatism	❑Yes ❑No Cough up Blood	❑Yes ❑No History of drug abuse	❑Yes ❑No Sexually transmitted diseases
❑Yes ❑No Artificial Heart Valves	❑Yes ❑No Diabetes	❑Yes ❑No HIV / AIDS	❑Yes ❑No Shortness of Breath
❑Yes ❑No Artificial Joints	❑Yes ❑No Dialysis	❑Yes ❑No Jaw Pain	❑Yes ❑No Sinus Problems
❑Yes ❑No Asthma	❑Yes ❑No Difficulty Breathing	❑Yes ❑No Kidney Disease	❑Yes ❑No Skin Rash
❑Yes ❑No Autism	❑Yes ❑No Emphysema	❑Yes ❑No Liver Disease	❑Yes ❑No Snoring/Sleep apnea
❑Yes ❑No Back Problems	❑Yes ❑No Epilepsy	❑Yes ❑No Low Blood Pressure	❑Yes ❑No Stroke
❑Yes ❑No Bleeding Tendency	❑Yes ❑No Fainting	❑Yes ❑No Mental Health problems	❑Yes ❑No Swelling of Feet/ Ankles
❑Yes ❑No Blood Disease	❑Yes ❑No Glaucoma	❑Yes ❑No Mitral Valve Prolapse	❑Yes ❑No Thyroid Problems
❑Yes ❑No Chemical Dependency	❑Yes ❑No Headaches	❑Yes ❑No Osteoporosis/Osteopenia	❑Yes ❑No Tobacco Habit
❑Yes ❑No Cancer	❑Yes ❑No Heart Attack(s)	❑Yes ❑No Pacemaker	❑Yes ❑No Tonsillitis
❑Yes ❑No Chemotherapy	❑Yes ❑No Heart Murmur	❑Yes ❑No Radiation Treatment	❑Yes ❑No Tuberculosis
❑Yes ❑No Circulatory Problems	❑Yes ❑No Heart Problems	❑Yes ❑No Respiratory Disease	❑Yes ❑No Tumor/Growth
❑Yes ❑No Contagious diseases	❑Yes ❑No Hemophilia	❑Yes ❑No Rheumatic Fever	❑Yes ❑No Ulcer
❑Yes ❑No Cortisone Treatments	❑Yes ❑No Hepatitis Type ___	❑Yes ❑No Scarlet Fever	❑Yes ❑No Venereal Disease

MEDICATIONS

Pharmacy Name:_____ Phone Number _____

Are you currently taking any kind of medication, drug, pills? .....❑Yes ❑No
Are you currently taking any blood thinners (Coumadin, Plavix, Aspirin, Vitamin E, Ginko Biloba)? .....❑Yes ❑No
Have you taken diet pills? ..... ❑Yes ❑No
Any natural product, herbal supplement or homeopathic remedy? ..... ❑Yes ❑No
Have you taken any bone density medications/Bisphosphonates (Aredia, Zometa, Fosamax, Actonel)? ..... ❑Yes ❑No

Please list any medications are currently taking:_____

_____

_____

_____

_____

ALLERGIES

Are you allergic to, or had a reaction to….

Local anesthetic (numbing medicine)? ..... ❑Yes ❑No
Penicillin? ..... ❑Yes ❑No
Other antibiotics? ..... ❑Yes ❑No
Sulfa Drugs? ..... ❑Yes ❑No
Aspirin? ..... ❑Yes ❑No
Codeine or other narcotics? ..... ❑Yes ❑No
Latex? ..... ❑Yes ❑No
Sulfites? ..... ❑Yes ❑No

Please list any other medications & other allergies that you have:_____

_____

_____

THIS SECTION IS FOR WOMEN ONLY, MEN CONTINUE BELOW.

Is there a possibility of pregnancy? ..... ❑Yes ❑No
Expected delivery date _____/_____/_____
Are you nursing? ..... ❑Yes ❑No
Are you taking birth control pills? ..... ❑Yes ❑No

Women Note: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding additional methods of birth control.

IN CASE OF EMERGENCY, CONTACT:

Name_____ Relationship _____

Home Tel._____ Cell_____ Work_____

PLEASE READ AND SIGN BELOW

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist or any of his staff responsible for any errors or omissions that I have made in the completion of this form.

X_____ X_____ X_____

Patient **OR** Parent/Guardian signature | Today's Date | Reviewed By

Authorization

I authorize my dentist and his designated staff, to perform an oral and maxillofacial examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x-rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment.

X_____ X_____ X_____

Patient **OR** Parent/Guardian signature | Today's Date | Reviewed By

Privacy Policy

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me.
I have been given the opportunity to ask any questions I may have regarding this Notice.

X_____ X _____

Patient **OR** Parent/Guardian signature | Today's Date

David C. Henderson D.M.D. General Dentistry, P.A.

Financial Policy

We are so pleased that you have chosen our practice to take care of your dental needs. We will do our very best to give you the most excellent dental care available. It is very important to us that we earn your trust.

So that we can prevent any misunderstanding and maintain a positive relationship with you, the following is the practice's financial policy. We thank you for your understanding and cooperation with these policies. After having read the policies, please sign at the bottom.

- **Payment due at the time of service** – We require that you pay on the date that the services are rendered (this includes children who drive themselves or are accompanied by another adult). We accept cash, checks, credit cards, and debit cards. We also accept CareCredit. Any balance not paid in full will be subject to a monthly finance charge.
- **Insurance Patients –** Patients who are fortunate to have dental insurance coverage will be required to pay their estimated co-payments at the time of service. A copayment is the amount that insurance does not pay based on the percentage of fees covered by the plan, the usual and customary fees that the insurance company follows, deductibles, and plan maximums. You will be responsible for paying fees in full when a claim is still unpaid after sixty (60) days.
- **Returned Checks** – If any checks are returned by the bank, we require that the check be immediately reimbursed in cash. A $25.00 returned check fee will be charged to your account. Your account will then be placed on a cash only basis.
- **Finance Charges** – Any balance that is accrued over 90 days will be charged a finance charge of 1.5%.
- **Broken Appointments** – We require that at least a twenty-four hour notice be given on appointment cancellations. If an appointment is cancelled in less than twenty-four hours or is broken it will be considered a "No-Show". There will be a charge of $35.00 for No Show appointments.

_____ _____

Patient **OR** Parent/ Guardian Signature Today's Date

NO SHOW/CANCELLATION POLICY

For

David C. Henderson, D.M.D. General Dentistry

Due to our high volume of patient appointments, it is imperative that we are notified in a timely manner if an appointment needs to be canceled or rescheduled.

Cancellation must be made 24 hours before the appointment. If you cancel without a 24 hour notice a fee of **$35** will be charged to your account.

For a **No Show** appointment, without prior notice, a **$35** fee will be charged to your account.

Please sign and date this agreement

_____ _____

Patient name Date