

DENTAL REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____ First Name _____ Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex M F Age _____

Birthdate _____

Married Widowed Single Minor

Separated Divorced Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

Employer/School Phone (____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 DENTAL INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? Yes No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to _____
Name of Insurance Company(ies)

Dr. _____ 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.

Signature of Patient, Parent, Guardian or Personal Representative

Please print name of Patient, Parent, Guardian or Personal Representative

Date

Relationship to Patient

3 PHONE NUMBERS

Home (____) _____ Work (____) _____ Ext _____ Cell Phone (____) _____

Spouse's Work (____) _____ Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home Phone (____) _____ Work Phone (____) _____

4 DENTAL HISTORY

Reason for today's visit _____	Burning sensation on tongue <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth breathing <input type="checkbox"/> Yes <input type="checkbox"/> No
_____	Chew on one side of mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth pain, brushing <input type="checkbox"/> Yes <input type="checkbox"/> No
Former Dentist _____	Cigarette, pipe, or cigar smoking <input type="checkbox"/> Yes <input type="checkbox"/> No	Orthodontic treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
City/State _____	Clicking or popping jaw <input type="checkbox"/> Yes <input type="checkbox"/> No	Pain around ear <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental visit _____	Dry mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Periodontal treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental X-rays _____	Fingernail biting <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to cold <input type="checkbox"/> Yes <input type="checkbox"/> No
Place a mark on "yes" or "no" to indicate if you have had any of the following:	Food collection between the teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to heat <input type="checkbox"/> Yes <input type="checkbox"/> No
Bad breath <input type="checkbox"/> Yes <input type="checkbox"/> No	Foreign objects <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to sweets <input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding gums <input type="checkbox"/> Yes <input type="checkbox"/> No	Grinding teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity when biting <input type="checkbox"/> Yes <input type="checkbox"/> No
Blisters on lips or mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Gums swollen or tender <input type="checkbox"/> Yes <input type="checkbox"/> No	Sores or growths in your mouth <input type="checkbox"/> Yes <input type="checkbox"/> No
	Jaw pain or tiredness <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you floss? _____
	Lip or cheek biting <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you brush? _____
	Loose teeth or broken fillings <input type="checkbox"/> Yes <input type="checkbox"/> No	

5 HEALTH HISTORY

Physician's Name _____ Date of last visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). Yes No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting or dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis, Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis Type _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Special Diet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding abnormally, with extractions or surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Feet or Ankles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Neck Glands	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Lesions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumor or growth on head or neck	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cortisone Treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough, persistent or bloody	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervous Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weight Loss, unexplained	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No		
		Radiation Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Do you wear contact lenses? Yes No

Women:

Are you pregnant? Yes No

Due date _____

Are you nursing? Yes No

Taking birth control pills? Yes No

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

Pharmacy Name _____

Phone (_____) _____

ALLERGIES

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Local Anesthetic
<input type="checkbox"/> Barbiturates (Sleeping pills)	<input type="checkbox"/> Penicillin
<input type="checkbox"/> Codeine	<input type="checkbox"/> Sulfa
<input type="checkbox"/> Iodine	<input type="checkbox"/> Other _____
<input type="checkbox"/> Latex	_____

6 UPDATES (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? Yes No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Has there been any change in your health since your last dental appointment? Yes No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Our Financial Policy

We would like to take this opportunity to thank you for being an important member of our dental family, and assure you of our continued commitment to excellence. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

Payment Options

In order to keep our fees from increasing and to minimize the expense of billing and accounting, we have chosen to offer our patients several financial options.

- 1.) Payment at time of treatment by cash, check or credit card. Please circle your preference.
- 2.) Pre-payment of a selected treatment plan in full (cash only) 10% courtesy (as per treating dentist)
 - In-Office finance plans that offer interest free loans (Care Credit) base on approved credit
 - I am responsible for the payment of all treatment fees on my account
 - I am responsible for estimated portion not paid by the insurance company at each visit
 - If upon payment by the insurance company there is a remaining balance, I am responsible for the amount in full at that time

Please be aware that some of the services provided may not be covered or may be reduced to an alternate benefit under your insurance plan. For example, most insurance companies will reduce their benefit for composite (white) fillings to the benefit of an amalgam (silver) filling.

OUR OFFICE DOES NOT ACCEPT ASSIGNMENT FROM SECONDARY INSUANCE.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Minor Patients

The adult accompanying a minor and parents (or guardians of minor) is responsible for full payment.

Missed Appointments

Unless cancelled at least 48 hours in advance our policy is to charge \$50.00 for missed appointments. Please help us serve you better by keeping scheduled appointments.

We appreciate your concern in our need to enforce these policies in order to deliver you, our valued patient, continued optimum care. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy.

X _____
Signature of Patient or Guardian

Date _____

Print Name signed above

Hampton Dentistry, P.C.
Notice and Consent of Privacy Practices and Policies

Dr. Baker (and her representatives/employees), will respect the individual rights of their patients in the use and disclosure of Individually Identifiable Health Information (IIHI).

Hampton Dentistry, P.C. will use and disclose (share) medical/dental information with other healthcare providers, healthcare entities and billing agencies only with the written consent/authorization of the patient or the legal guardian of the patient.

The information used and disclosed will be only the information necessary to properly conduct the care, treatment, and billing of a patient.

Information regarding psychiatric, psychotherapy, or HIV testing will require an additional authorization form.

Patients must give additional authorization in writing if this office is to speak with the patient's attorney concerning his/her medical/dental records and/or care.

This consent/authorization may be limited, restricted and/or revoked at any time in writing by the patient or legal guardian.

All employees of Hampton Dentistry, P.C. will follow the privacy practices set forth by this office and shall respect the privacy rights of the patients of this office.

A complete copy of Hampton Dentistry P.C.'s Privacy Policy was offered to me at the time of my visit to read in full.

A complete copy of this Privacy Policy is available to me upon request at any time.

Signature

Date

HAMPTON DENTISTRY, P.C.

Danielle M. Baker, D.D.S

John E. Baker, D.D.S

27 Old Riverhead Road

Westhampton Beach, NY 11978

631-998-3980

RELEASE OF RECORDS

Please provide me with copies of all of my dental treatment records, including diagnostic x-rays and any other materials, notes or copies of medications prescribed. I understand that original records and x-rays are your property. I agree to accept copies and to pay reasonable fees for such copies.

I READ AND UNDERSTAND THE ABOVE INFORMATION AND THE INFORMATION GIVEN ME VERBALLY. BY MY SIGNATURE BELOW I CONSENT TO THE TREATMENT DESCRIBED IN THIS PAPER.

Patient Signature _____ Date _____

Witness _____ Date _____

Please complete, so we may contact to obtain records if necessary:

Dr.'s name: _____

Address:(Street) _____

(City) _____ (State) _____ (Zip Code) _____

Phone #: _____