DENTAL REGISTRATION FORM

Name: _____ DOB: _____ Age: ____ Gender: M F Phone: _____

Mailing Address: _____ City: _____ State: ___ Zip Code: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Health Insurance? Y N Dental Insurance? Y N ID: _____ SS#: _____

If Patient is a Minor (below 18 yrs. of age) please list accompanying Guardian's information:

Name: _____ Relationship: _____ Phone: _____

HEALTH HISTORY (check all that apply)				ALLERGIES (check all that apply)	
	Joint Replacement (Hip / Knee/ Other)		High/Low Blood Pressure		Local Anesthetic
	Heart Valve Replacement		Tuberculosis		Latex
	Endocarditis		Anemia		Cephalosporin
	Heart Stent		Asthma		Clindamycin
	HIV or AIDS		Radiation Treatment		Doxycycline
	Lupus		Excessive Bleeding		Erythromycin
	Diabetes		Osteoarthritis		Fluoroquinolones
	Heart Disease		Osteoporosis		Metronidazole
	Shunts		Prosthetics		Penicillin
	Heart Murmur		Hearing/Vision Loss		Spectinomycin
	Bleeding Disorders		Stroke		Sulfa
	Malaria/Parasites		Tobacco Use		Tetracycline
	Rheumatoid Arthritis		Alcohol Use		Other (list):
	Heart Attack		Currently Pregnant		
	Cancer		Hepatitis (circle applicable) A B C		

Are you presently under a physician's care **Yes** **No**	Date of Last Medical Visit:
Physician's Name:	Phone:
Medical Restrictions:	Date of Last Dental Exam:
Recent Hospitalizations:	Recent Surgeries:

MEDICATION LIST (Including Over the Counter)
Do you take any blood thinners (Aspirin, Plavix, Coumadin, etc.?) **Yes** **No** Name?
Medication Name(s):

I affirm that the information I have provided is true to the best of my knowledge.

Signature (If Minor, Guardian must sign): _____ Date: _____

Health Partners, Inc. "Notice of Privacy Practices" provides information about how we may use and disclose protected health information about you. Our **Notice of Privacy Practices** states that we reserve the right to change the terms described. Should this happen, you will receive a revised copy by mail or in person. Please acknowledge understanding of this office's **Notice of Privacy Practices** by initialing.

Initials: _____

DENTAL REGISTRATION FORM

You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or health care operations. We are not required to agree, but if we do we are bound by our agreement with you. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent in writing, except where we have already made disclosures in trust on your prior consent.

May we phone or email you to confirm appointments? Yes No

May we leave a message on your answering machine at home or on your cell phone? Yes No

May we discuss your condition/treatment with any member of the family? Yes No

If yes, please name the members allowed: _____

Signature: _____ Date: _____

CLIENT RESPONSIBILITIES

- I agree to provide Health Partners with up-to-date, complete and accurate proof of income and permit Health Partners to verify income, number of dependents, place of residence, and insurance coverage.
- I agree to notify Health Partners immediately of changes of address, phone, marital status, insurance status and employment status.
- I will contact Health Partners at least 24 hours in advance to cancel appointments. Three missed appointments, without cancelling 24 hours prior to appointment results in restriction to "same-day only" appointment status.
- I understand that verbal affirmation of appointment 24 hours in advance is required to verify appointment confirmation. Without verbal affirmation, scheduled appointments will be released and made available to other patients.
- I agree to have prescriptions filled and take medications as directed.
- I understand that carrying a weapon or illegal object on the premises of Health Partners is grounds for discharge from clinic.

I understand and agree with my responsibilities as a patient of Health Partners.

Signature: _____ Date: _____

I hereby authorize Health Partners' volunteers and staff to perform upon me those dental procedures we have discussed and I have accepted. If any unforeseen condition arises in the course of these designated procedures calling, in their judgment, for procedures in addition to or different from those contemplated, I further request and authorize whatever they deem advisable. I consent to the treatment plan I have accepted after having been advised of alternate plans of treatment available.

Initials: _____

I am informed and fully understand that there are certain risks in any dental treatment. The most common of these complications include post-treatment pressure and temperature sensitivity, post-operative bleeding, post-operative pain and throbbing, swelling or bruising, discomfort, stiff jaws and loss or loosening of dental restorations, fracturing of new restorations due to early biting pressure, tenderness of abutment teeth/tissue under removable dentures, and fracturing of files or the crown portion of the tooth during/following root canal therapy. Other less common complications include, but are not limited to: infection, loss or injury to adjacent teeth and soft tissues, jaw fractures, sinus exposure and swallowing or aspiration of teeth and restorations, nerve disturbances (e.g. numbness in mouth and lip tissues) and small root fragments remaining in the jaw which might require extensive surgery for removal. These complications may be temporary or permanent.

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I further consent to the administration of any drugs that may be deemed necessary in my case, including, but not limited to local anesthetics, antibiotics and analgesics. I understand that there is a slight element of risk inherent in the administration of any drug or anesthesia.

This risk includes, but is not limited to, the following complications: adverse drug response (e.g. allergic reactions), cardiac arrest, thrombophlebitis (e.g. irritation and swelling of a vein), aspiration, pain, discoloration and injury to blood vessels and nerves which may be caused by injections of any medication or drugs. A more complete explanation of all possible complications is available to me upon my request of the doctor.

Initials: _____

I am aware that, in spite of the possible complications and risks, my treatment is necessary and desired by me. I realize that the practice of dentistry is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of the procedures.

Signature: _____ Date: _____ Staff: _____

STATEMENT OF FINANCIAL RESPONSIBILITY

Health Partners appreciates the confidence you have shown in choosing us to provide for your primary care/dental needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf if applicable. However, you are ultimately responsible for payment of your bill.

If insured, you are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your provider elects to continue past your approved period, you will be responsible for your balance.

For any services not covered by your insurer, and for those who are not currently covered under an insurance carrier, Charles County residents will be placed on a “sliding scale” based upon provided household income. If sufficient proof of household income is not provided at the time of service, you will be responsible for the full fee associated with all non-covered services. Out of county residents are responsible for the full fee of all non-covered services.

All patients for whom insurance cannot be verified due to lack of coverage at the time of your visit will be responsible for a fee per service. All service related fees associated with the visit will be calculated at the time of checkout. Patients will be responsible for the full amount due before a subsequent appointment will be scheduled.

I have read the above policy regarding my financial responsibility to Health Partners for providing services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Health Partners, the full and entire amount of bill incurred by me or the above named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

If at the time of visit I do not have health insurance, I understand that I will be responsible for services rendered here at Health Partners. I agree to pay Health Partners the full and entire amount of treatment given to me or to the above named patient at each visit.

Verified Insurance: _____ SFS Determination: _____ Staff Initials: _____

Patient Signature: _____ Date: _____