REGISTRATION AND TREATMENT

Cell Phone_____

Date_____ Email_____Home Phone _____

PATIENT INFORMATION

Name _____ Soc. Sec # _____
Last Name First Name Middle Initial

Address_____

City _____ State _____ Zip _____

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

Patient Employed By _____ Occupation _____

Business Address _____ Business Phone_____

Whom may we thank for referring you? _____

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

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Middle Initial

Relation to patient_____ Birthdate _____ Soc. Sec # _____

Address (if different from patient) _____ Phone _____

City _____ State _____ Zip _____

Person Responsible Employed By _____ Occupation _____

Business Address _____ Business Phone_____

Insurance Company _____

Contract # _____ Group #_____ Subscriber #_____

Names of other dependents covered under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____
Last Name First Name Middle Initial

Relation to patient_____ Birthdate _____ Soc. Sec # _____

Address (if different from patient) _____ Phone _____

City _____ State _____ Zip _____

Subscriber Employed By _____ Business Phone _____

Insurance Company _____

Contract # _____ Group #_____ Subscriber #_____

Names of other dependents covered under this plan _____

Crestview FAMILY DENTAL

Patient Name _____

DENTAL HISTORY

Reason for today's visit_____

Previous Dentist _____

Address_____

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

How often do you floss? _____ How often do you brush? _____

Is there anything you dislike or would like to change about your teeth, bite or smile? _____

Check (√) if you have had problems with any of the following:

□ Bad Breath	□ Grinding teeth	□ Sensitivity to hot and/or cold	□ Sensitivity to sweets
□ Sensitivity to biting	□ Bleeding gums	□ Periodontal treatment	□ Loose teeth
□ Clicking/popping jaw	□ Broken fillings	□ Food collection between teeth	□ Sores or growths in your mouth

MEDICAL HISTORY

Physician's Name _____ Date of last visit_____

Have you had any serious illnesses or operations? □ Yes □ No If yes, describe _____

Do you bruise easily? □ Yes □ No

Have you ever had a blood transfusion? □ Yes □ No If yes, give approximate dates _____

(Women) Are you pregnant? □ Yes □ No Nursing? □ Yes □ No Taking birth control pills? □ Yes □ No

Check (√) if you have or have had any of the following:

□ AIDS	□ Cortisone Treatments	□ Hepatitis B or C	□ Respiratory Disease
□ Anemia	□ Cough, Persistent	□ High Blood Pressure	□ Rheumatic Fever
□ Angina	□ Cough up blood	□ HIV Positive	□ Scarlet Fever
□ Arthritis, Rheumatism	□ Diabetes	□ Kidney Disease	□ Shortness of breath
□ Artificial Heart Valves	□ Down's Syndrome	□ Learning Disability	□ Skin Rash
□ Artificial Joints	□ Epilepsy	Describe _____	□ Stroke
□ Asthma	□ Fainting	□ Mental Health Conditions	□ Swelling of feet or ankles
□ Autism	□ Glaucoma	Describe _____	□ Thyroid Conditions
□ Blood Disease	□ Headaches	□ Mitral Valve Prolapse	□ Tobacco habit
□ Cancer	□ Heart Murmur	□ Nervous Conditions	□ Tonsillitis
□ Chemical Dependency	□ Heart Conditions	□ Pacemaker	□ Tuberculosis
□ Chemotherapy	Describe _____	□ Psychiatric care	□ Ulcer
□ Circulatory Conditions	□ Hemophilia	□ Radiation Treatment	□ C Pap/Sleep Apnea
□ Recreational Drugs	□ Osteoporosis	□ Alzheimers	□ Dementia

MEDICATIONS

_____

_____

_____

ALLERGIES

_____

_____

_____

DENTAL HISTORY

- I authorize my insurance company to pay to the dental office all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.
- I authorize the dentist to release all information necessary to secure the payment of benefits.
- I understand that I am financially responsible for all charges whether or not they are paid for by insurance.

Signature _____ Date _____

Payment is due in full at time of treatment unless prior arrangements have been approved.

CRESTVIEW FAMILY DENTAL, LLC

PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION

DICLOSURE FORM

I. Acknowledge of Practice's Notice of Privacy Practices:

By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I chose) and understand the Notice of Privacy Practices (NPP) and agree to its terms.

Name of Patient	Date of Birth	Signature of Patient/Parent/Guardian	Date
Name of Patient	Date of Birth	Signature of Patient/Parent/Guardian	Date
Name of Patient	Date of Birth	Signature of Patient/Parent/Guardian	Date
Name of Patient	Date of Birth	Signature of Patient/Parent/Guardian	Date

II. Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative:

I agree that the practice may disclose certain of my health information to a Personal Representative of my choosing, since such person is involved with my health care or payment relating to my health care. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my health care of payment relating to my health care.

Print Name: _____ Home Phone: _____Cell Phone: _____

Print Name: _____ Home Phone: _____ Cell Phone: _____

Print Name: _____ Home Phone: _____ Cell Phone: _____

Print Name: _____ Home Phone: _____ Cell Phone: _____

CRESTVIEW FAMILY DENTAL, LLC

PATIENT HIPPA ACKNOWLEDGEMENT AND DESIGNATION

DICLOSURE FORM 2

III. Request to Receive Confidential Communications by Alternative Means:
As provided by Privacy Rule Section 164.522(b), I hereby request that the Practice make all communications to me by alternative means that I have listed below.

Home Telephone Number: **Written Communication Address:**

_____ _____

_____OK to leave message with detailed information _____OK to mail to address listed above

_____ Leave message with call back numbers only _____ E-mail me at: _____

Work Telephone Number: **Fax Communication:**

_____ _____

_____ OK to leave message with detailed information _____ OK to Fax at the number listed above

_____ Leave message with call back numbers only _____ E-mail me at: _____

Other: _____

Name of Patient (Print) **Signature** **Date**

Witness: _____ Date _____