Riverside FAMILY DENTAL

New Patient Registration Form Rev. 2019.05.29

NAME				
Birthdate		☐ Male ☐ Female	SSN	
Phones	Home	Cell	Office	

Street		2nd Add. Street	
City/ST/Zip		2nd City/ST/Zip	
Email		Referred by	

☐ Married ☐ Single ☐ Widowed ☐ Other | Emergency Contact | Phone

Initial Reason for visit: ☐ Cleaning/Exam ☐ Periodontal Maintenance ☐ Emergency ☐ Whitening ☐ Invisalign ☐ Other :

If exam indicated different/additional treatment is needed, treatment plan will be presented before proceeding.

Last Dental Visit		Last X-Rays		☐ Request Records be sent to Dr. Hamilton
Dentist/Practice			Street address if known	
Phone			City, State	

Will we be filing dental insurance? ☐YES ☐NO **Does any immediate family member have separate dental insurance? ☐YES ☐NO**

Insurance Co.		Employer			
Insured Name		Group Name or #			
Insured DOB		Group Plan			
Insured SSN		Ins. Phone		Ins. Payer ID	
Mbr/Subs ID		Please present your cards for all dental insurance, TriCare, and FED to our receptionist to copy!			

RATE YOUR SMILE! Place an X on the line below to indicate how you feel about your smile and your dental health:

Do I have to? | Not great… | Okay. | Pretty good. | Good. | Better than Average! | Great! | Perfect!

I use □ Manual Toothbrush □ Electric Toothbrush □ Manual Floss □ Electric "Flosser" (Water/Air) □ Tongue Cleaner

If money were no object, I would consider □ Straightening □ Whitening □ Adding a Twinkle □ _____

□ Yes □ No A dental professional has instructed me in proper oral hygiene.

VERIFICATION/AUTHORIZATION: Please complete the medical/dental history before reading and signing below!

Information Accuracy

My signature below indicates that I understand and have provided accurate responses on this registration and medical history form. I understand that providing incorrect or incomplete medical information can endanger my health.

Treatment Authorization

I hereby authorize Riverside Family Dental, PA, to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Hamilton to make a thorough diagnosis of the patient's dental needs. I also authorize Dr. Hamilton to perform any and all forms of treatment, medication and therapy that may be indicated. I understand the use of anesthetic agents embodies a certain risk.

Information Sharing Authorization

I authorize Riverside Family Dental to receive/ share necessary information regarding diagnosis, records, or treatment from/with third party payors (insurers) and/or health practitioners.

Financial Responsibility

I understand that as the patient /parent/legal guardian, I am responsible for payment at the time of treatment. If have dental insurance, I have provided current coverage information for Riverside Family Dental, PA, to submit claims on my behalf and to receive payments directly from my insurer for all services. I understand that I am responsible for paying any anticipated deductibles and "patient portions" at the time of treatment, and that I am responsible to pay any difference between the anticipated and actual insurance payments, as well as any treatment costs exceeding my available benefits, after Dr. Hamilton's office has provided a statement of any balance due.

_____ _____ _____

(Choose one) □ Patient □ Parent □ Guardian Signature Date Dentist Signature

MEDICAL INFORMATION Please help us provide the most appropriate care by checking each item either **Y** (Yes) or **N** (No).

NAME		DOB	/ /	BP	/	INITIALS	

DENTAL HISTORY

	Y	N		Y	N		Y	N
Dental visit past year			Bite lips / cheeks frequently			Dentures / partials since _____		
Pain in teeth / jaw (#days? _____)			Clench or grind teeth			**Jaw Problems:**		
Gums bleed when flossing/brushing			Difficult tooth extractions in past			Neck or Jaw injuries		
Periodontal Treatment/"Deep Cleaning"			Frequent headaches			Clicking		
Persistent bad breath			Prolonged bleeding after teeth pulled			Pain (joint /side of face /when eating)		
Sensitive to hot / cold			Orthodontic treatment (prior or now)			Difficulty opening/closing mouth		
Sensitive to sweet / sour			Sores/lumps in/on/near mouth			Difficulty chewing		

Other Dental:

HISTORY Do you have, or have you ever had, any of the following?

	Y	N		Y	N		Y	N		Y	N
AIDS			Drug Addiction			HPV (Human Papilloma Virus)			Respiratory Problems		
Allergies (Seasonal)			Emphysema			Jaundice			Rheumatic Fever		
Anemia			Epilepsy/Convulsions			Jaw Joint Pain			Rheumatism		
Angina or Chest Pain			Excessive Bleeding			Joint Replacement			Scarlet Fever		
Arthritis			Fainting			Kidney Disease			Seizures		
Artificial Heart Valve			Glaucoma			Liver Disease			Shortness of Breath		
Asthma			Heart Condition			Low Blood Pressure			Sinus Problems		
Blood Disease			Heart Lesions (congenital)			Mitral Valve Prolapse			Sleep Apnea		
Bruise Easily			Heart Murmur			Nervousness/Depression			Stomach Problems		
Cancer			Heart Surgery			Nursing			Stroke		
Cervical Cancer			Hepatitis A			Pacemaker			Swelling of Feet/Ankles		
Chemotherapy			Hepatitis B			Persistent Cough			Thyroid Disease		
Cortisone Medication			Hepatitis C			Pregnant			Tuberculosis		
Diabetes			High Blood Pressure			Radiation Therapy			Ulcers		
Dizziness			HIV Positive			Recent Weight Loss			Venereal Diseases (STDs)		

Other – please include surgeries:

Do you use or have you used tobacco products? ____Y ____N What tobacco products do you use?

EPIPEN

	Y	N
EpiPen Rx or use?		

ALLERGIES Are you allergic to, or have you reacted adversely to, any of the following?

	Y	N		Y	N		Y	N		Y	N		Y	N		Y	N
Foods			Food Coloring			Latex			Bites/Stings			Fruit						

MEDICATION ALLERGIES

	Y	N		Y	N		Y	N		Y	N
Barbiturates			Darvon			Nitrous Oxide			Sedatives		
Aspirin			Erythromycin			Penicillin			Steroids		
Codeine			Local Anesthetic			Percodan			Sulfa/Sulfites		

OSTEOPOROSIS MEDICATIONS Have you taken any of the following bisphosphonate medications, even once?

	Y	N		Y	N		Y	N		Y	N		Y	N		Y	N
Actonel			Aredia			Boniva			Fosamax			Reclast			Zometa		

BLOOD THINNERS: Are you currently taking any blood thinners? Y___ N___ If so, what medication?

OTHER MEDICATIONS Include ALL regularly used prescription drugs, dietary supplements, herbals, vitamins, and over-the-counter preparations.

Dose	**Medication** (include those given in-office)	**Taken to treat what condition/symptoms/disease?**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA)

I _____, have had opportunity to read the Notice of Privacy Practices (posted in reception window) of Riverside Family Dental, PA.

I have reviewed and agree to the Notice of Privacy Practices.

(Check appropriate box) □ Patient □ Parent □ Guardian

Signature _____ **Date** _____

AUTHORIZATION TO RELEASE INFORMATION

Purpose: This form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself.

I, _____, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

_____	_____
Please Print Name	Relationship
_____	_____
Please Print Name	Relationship
_____	_____
Please Print Name	Relationship

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 it*
□ *An emergency prevented obtaining it*
□*Other(specify)* _____

_____

Employee signature _____ Date _____

Riverside Family Dental, P.A. **Dr. Holly Hamilton, DMD**
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FRAGRANCE POLICY

Due to staff allergies, please refrain from wearing perfume or cologne to our office.

Thank you!

APPOINTMENT CANCELLATION / MISSED APPOINTMENTS POLICY

We strive to render excellent dental care to you and the rest of our patients. In an attempt to be consistent with this, we have an **Appointment Cancellation Policy**. When an appointment is scheduled, that time has been set aside for you and when it is cancelled or missed, that time cannot be used to treat another patient.

Our policy is as follows:

We require that you give the office **at least 24 hours notice** in the event that you need to reschedule your appointment. This allows for other patients to be scheduled into that appointment. If you miss an appointment without contacting our office within the required time, this is considered a missed appointment. A fee of $35 will be charged to you; this fee cannot be billed to your insurance company and will be your direct responsibility. No future appointments can be scheduled nor can records be transferred without the payment of this fee.

Additionally, if a patient is more than 20 minutes late without prior notice for a scheduled appointment, we will consider this a missed appointment and the $35 cancellation fee may be charged. Patients that miss more than one appointment or consistently cancel appointments within the 24 hours may not be rescheduled and may be dismissed from the practice. We do know that some emergencies do occur so if something does happen, please contact us right away!

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have.

We thank you for trusting your teeth to our care and look forward to a long term relationship in helping to meet your dental needs.

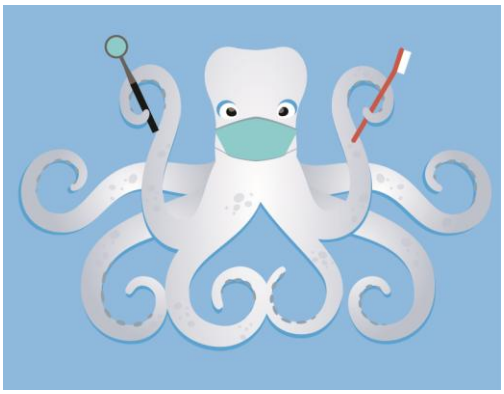
I have read and understand the Appointment Cancellation Policy of this practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

I _____ (print name), have reviewed this copy of Riverside Family Dental's Appointment Cancellation Policy.

_____ _____

Signature of Patient **Date**

Patient Name (print) _____



FINANCIAL POLICY

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality of dental care, so that you may attain optimum oral health. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment. Payment is due at the time service is provided. Our office accepts cash, personal checks, credit cards and outside patient financing, such as Care Credit.

X_____ I understand that I am personally responsible for payment of all fees for dental services provided in this office for me or my dependents, regardless of insurance coverage. Breach of this responsibility carries the penalty of compensating the practice for any related attorney's and collection fees, in addition to payment of the balance owed for dental services rendered.

Please check if you would like more information about financing options. _____

Please note: Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance; you will be responsible for any collection and/or legal charges.

Consent:

I have read, understand and agree to the above terms and conditions. If I have insurance, I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that responsibility for payment for Dental Services provided in this office for myself of my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge and/or attorney fee will be added to any overdue balance. By signing below, you are authorizing us to call you at any number you provide including calls to mobile/cellular or similar devices for any lawful purpose. You agree to any fees or charges that you may incur for an incoming call from us, and/or outgoing calls to us, to or from any such number, without reimbursement from us.

X_____ X_____

Signature (Parent if child) **Date**