

ID: \_\_\_\_\_ Chart ID: \_\_\_\_\_

### PATIENT REGISTRATION

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Patient is:  Policy Holder  Responsible Party Preferred First Name \_\_\_\_\_

\_\_\_\_\_ Responsible Party \_\_\_\_\_

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Address 1 \_\_\_\_\_ Address 2 \_\_\_\_\_

City, State, ZIP \_\_\_\_\_

Home (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Soc Sec \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Drivers Lic#/State \_\_\_\_\_

Responsible Party is also a Policy Holder for Patient  Primary Insurance Policy Holder  Secondary Insurance Policy Holder

\_\_\_\_\_ Patient Information \_\_\_\_\_

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Address 1 \_\_\_\_\_ Address 2 \_\_\_\_\_

City, State, ZIP \_\_\_\_\_

Home (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Email \_\_\_\_\_  I would like to receive correspondence by email

Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Soc Sec \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Drivers Lic#/State \_\_\_\_\_

Sex  Male  Female Marital Status  Married/Dom Partner  Single  Divorced  Separated  Widowed

Employment  FT  PT  Retired  Unemployed  House Spouse  N/A Student  FT  PT  N/A

Medicaid ID \_\_\_\_\_ Employer ID \_\_\_\_\_ Carrier ID \_\_\_\_\_

Preferred Dentist \_\_\_\_\_ Preferred Hygenist \_\_\_\_\_

Pharmacy \_\_\_\_\_

Referred by \_\_\_\_\_ Prev Dentist \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

\_\_\_\_\_ Primary Insurance Information \_\_\_\_\_

Name of Insured \_\_\_\_\_ Relationship to Insured  Self  Spouse/Dom Par  Child  Other

Insured SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Insured Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer \_\_\_\_\_ Ins. Company \_\_\_\_\_

Address 1 \_\_\_\_\_ Address 1 \_\_\_\_\_

Address 2 \_\_\_\_\_ Address 2 \_\_\_\_\_

City/State/Zip \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Rem. Benefit \_\_\_\_\_ Rem. Deductible \_\_\_\_\_

\_\_\_\_\_ Secondary Insurance Information \_\_\_\_\_

Name of Insured \_\_\_\_\_ Relationship to Insured  Self  Spouse/Dom Par  Child  Other

Insured SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Insured Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer \_\_\_\_\_ Ins. Company \_\_\_\_\_

Address 1 \_\_\_\_\_ Address 1 \_\_\_\_\_

Address 2 \_\_\_\_\_ Address 2 \_\_\_\_\_

City/State/Zip \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Rem. Benefit \_\_\_\_\_ Rem. Deductible \_\_\_\_\_

# MEDICAL HISTORY

Patient Name \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Although dental personnel primarily treat the area in and 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 dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?  Yes  No If yes, please explain \_\_\_\_\_

Have you ever been hospitalized or had a major operation?  Yes  No If yes, please explain \_\_\_\_\_

Have you ever had a serious head or neck injury?  Yes  No If yes, please explain \_\_\_\_\_

Are you taking any medications, pills, or drugs?  Yes  No If yes, please list \_\_\_\_\_

Do you take, or have you taken, Phen-Fen or Redux?  Yes  No

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?  Yes  No

Are you on a special diet?  Yes  No

Do you use tobacco?  Yes  No Women only  Pregnant/Trying to get pregnant  Nursing  Taking oral contraceptives

Do you use controlled substances?  Yes  No

Are you allergic to any of the following?  Aspirin  Penicillin  Codeine  Acrylic  Metal  Latex  Local Anesthetics  Sulfa Drugs  Other-please explain: \_\_\_\_\_

- |   |  |  |  |   |
|---|--|--|--|---|
| <input type="checkbox"/> AIDS/HIV Positive      | <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Glaucoma              | <input type="checkbox"/> Leukemia              | <input type="checkbox"/> Sickle Cell Disease        |
| <input type="checkbox"/> Alzheimer's Disease    | <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Hay Fever             | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Sinus Trouble              |
| <input type="checkbox"/> Anaphylaxis            | <input type="checkbox"/> Convulsions               | <input type="checkbox"/> Heart Attack/Failure  | <input type="checkbox"/> Low Blood Pressure    | <input type="checkbox"/> Spina Bifida               |
| <input type="checkbox"/> Anemia                 | <input type="checkbox"/> Cortisone Medicine        | <input type="checkbox"/> Heart Murmur          | <input type="checkbox"/> Lung Disease          | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Angina                 | <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> Heart Pacemaker       | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> Arthritis/Gout         | <input type="checkbox"/> Drug Addiction            | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Osteoporosis          | <input type="checkbox"/> Swelling of Limbs          |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Easily Winded             | <input type="checkbox"/> Hemophilia            | <input type="checkbox"/> Pain in Jaw Joints    | <input type="checkbox"/> Thyroid Disease            |
| <input type="checkbox"/> Artificial Joint       | <input type="checkbox"/> Emphysema                 | <input type="checkbox"/> Hepatitis A           | <input type="checkbox"/> Parathyroid Disease   | <input type="checkbox"/> Tonsillitis                |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Epilepsy or Seizures      | <input type="checkbox"/> Hepatitis B or C      | <input type="checkbox"/> Psychiatric Care      | <input type="checkbox"/> Tuberculosis               |
| <input type="checkbox"/> Blood Disease          | <input type="checkbox"/> Excessive Bleeding        | <input type="checkbox"/> Herpes                | <input type="checkbox"/> Radiation Treatments  | <input type="checkbox"/> Tumors or Growths          |
| <input type="checkbox"/> Blood Transfusion      | <input type="checkbox"/> Excessive Thirst          | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Recent Weight Loss    | <input type="checkbox"/> Ulcers                     |
| <input type="checkbox"/> Breathing Problem      | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> High Cholesterol      | <input type="checkbox"/> Renal Dialysis        | <input type="checkbox"/> Venereal Disease           |
| <input type="checkbox"/> Bruise Easily          | <input type="checkbox"/> Frequent Cough            | <input type="checkbox"/> Hives or Rash         | <input type="checkbox"/> Rheumatic Fever       | <input type="checkbox"/> Yellow Jaundice            |
| <input type="checkbox"/> Cancer                 | <input type="checkbox"/> Frequent Diarrhea         | <input type="checkbox"/> Hypoglycemia          | <input type="checkbox"/> Rheumatism            |   |
| <input type="checkbox"/> Chemotherapy           | <input type="checkbox"/> Frequent Headaches        | <input type="checkbox"/> Irregular Heartbeat   | <input type="checkbox"/> Scarlet Fever         |   |
| <input type="checkbox"/> Chest Pains            | <input type="checkbox"/> Genital Herpes            | <input type="checkbox"/> Kidney Problems       | <input type="checkbox"/> Shingles              |   |

Do you have, or have you had, any illness not listed above?  No  Yes If yes, please explain \_\_\_\_\_

Comments \_\_\_\_\_

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Financial Agreement

This financial agreement is between Aaron Smitka, D.D.S. 104 Archibald St, Kansas City, MO 64111 816-531-0382 and \_\_\_\_\_, the responsible party for the patient \_\_\_\_\_.

If you have dental benefits, we will help you receive maximum benefits by filing for you. We will expect payment of estimated copays, coinsurance and deductibles at the time of service. We accept Mastercard, Visa, Check and Cash.

As a patient (or guardian of a patient) I understand that this office does not acknowledge agreements between parents accepting or denying responsibilities of services provided. We consider the custodial guardian/parent to be responsible for payment of services received.

Assignment of Insurance Benefits I hereby assign benefits to be paid, on my behalf, to Aaron Smitka, D.D.S. I understand and agree to be financially responsible for charges not covered or paid by dental benefits.

By entering my name below I acknowledge the above financial agreement.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN

\_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN

\_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_