New Patient Registration Form

Patient Information And General Consent For Treatment

Title: Mr.__ Mrs.__ Ms.__ Dr.__
First Name: _____
Middle Initial: _____
Last Name: _____
Sex: M__ F__ Age:_____
Date of Birth:_____
Street Address:_____
City:_____
State:_____ Zip:_____
Social Security #:_____
E-mail:_____
Spouse Name: _____
Emergency Contact Name and phone # _____

Home Tel. #:_____
Mobile Tel#:_____
Employer Name:_____
City:_____
State:_____ Zip:_____
Work Tel. #: _____Ext.:____
Occupation:_____
Physician Phone#:_____
Referred By: _____
Relation: _____

Account Responsibility/Insurance Card Holder

Who will be responsible for your account? (if patient is a minor)
Relation: Self__ Spouse__ Father__ Mother__ Other (please specify)_____
Title: Mr.__ Mrs.__ Ms.__ Dr.__
First Name:_____
Middle Initial:_____
Last Name:_____
Street:_____
City:_____
State:_____ Zip:_____

Date of Birth: _____
Social Security _____
Driver's License #:_____
Home Tel. # _____
Mobile Tel. #:_____
Employer Name:_____
Emp. Tel. #:_____

Spouse or Guarantor Info (if different from above)

Title: Mr.__ Mrs.__ Ms.__ Dr.__
First Name:_____
Middle Initial:_____
Last Name:_____
Street:_____
City: _____ State:___ Zip:_____

Social Security #:_____
Tel. #:_____
Mobile Tel#:_____
Employer Name:_____
Emp. Tel.#:_____
Relation:_____

Primary Dental Insurance

Employer Name:_____
Emp. Tel. #:_____
Ins. Co. Name:_____
Insurance Tel. #:_____
Insurance PO Box: _____
Relationship to Patient: Self __ Spouse__ Father__ Mother__ Other_____

Group #:_____
Subscriber Name:_____
Subscriber Birthday:_____
SSN/ID/Contract#: _____

Secondary Insurance

Employer Name:_____
Emp. Tel. #:_____
Ins. Co. Name:_____
Insurance Tel. #:_____
Insurance PO Box: _____
Relationship to Patient: Self __ Spouse__ Father__ Mother__ Other_____

Group #:_____
Subscriber Name:_____
Subscriber Birthday:_____
SSN/ID/Contract #:_____

Fees and Payments

We make every effort to keep down the cost of your dental care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure you may require will be given to you upon request. If you have any dental insurance we will be glad to fill out the proper forms.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.

I authorize the release of information necessary to process my claim. I hereby authorize to this doctor named of the benefits otherwise payable to me.

_____

Patient/Guardian Signature

Patient Acknowledgements

I hereby acknowledge that I have been given the right to review this office's Notice of Privacy Practices. (HIPAA) A copy of this notice will be provided in office. If you would like to request a copy to keep, please notify the front desk.

I hereby authorize the release of my personal information to the following relatives or individuals:

Name:_____

Name:_____

This authorization will not expire unless revoked by you giving us written notice of such revocation.

I certify that I have read and understand the above. I affirm that the information contained in this form and any additional information that I may furnish is true and correct to the best of my knowledge.

_____

Patient/Guardian Signature

Appointment Cancellation Policy

We make every effort to appoint you for your convenience. We require that you give our office at least a 24-hours-notice in the event that you need to reschedule your appointment. This allows for other patients to be scheduled into that appointment. Missed appointments or cancellations without a 24 hours' notice will be issued a $40 fee per hour of scheduled time.

_____

Patient/Guardian Signature

GENERAL HEALTH

Are you in relatively good health? Y/N
Have there been any changes in your general health in the past year? Y/N
Are you under the care of a physician? Y/N
Have you had any illness, operation or been hospitalized in the past five years? Y/N
Do you have inflamed areas, growths or sore spots in or around your mouth? Y/N
Are there conditions that the doctor should be aware of? Y/N
Date of last dental visit: _____
Dental Complaint: _____

CONDITIONS (PLEASE CHECK ALL THAT APPLY)

- ☐ High / Low blood pressure
- ☐ Chest pain / Angina
- ☐ Irregular heartbeat
- ☐ Heart Murmur /MVP
- ☐ Cardiac pacemaker
- ☐ Heart Surgery/Heart attack(s)
- ☐ Stroke
- ☐ Bleeding Tendency/Bruise easily
- ☐ Asthma / Emphysema
- ☐ I smoke # cig/day_____ #pk/day_____
- ☐ Alcohol # of glasses/ day___/ wk.____
- ☐ Bronchitis / Difficult breathing
- ☐ Hay fever/Sinus problems/Seasonal
- ☐ Tuberculosis/ chronic cough
- ☐ Thyroid problems
- ☐ Problems with the immune system
- ☐ Rheumatic fever
- ☐ Swollen ankles, arthritis, joint disease, prosthetic joint
- ☐ Chronic fatigue / Night sweats
- ☐ Diabetes Type I, Type II
- ☐ Stomach ulcers/ GERD
- ☐ High cholesterol/ triglycerides
- ☐ Anxiety/ Depression/ Other
- ☐ History of drug / Alcohol abuse
- ☐ Convulsions / Epilepsy
- ☐ Fainting spells
- ☐ Cancer or Tumor
- ☐ X-Ray treatment / Chemotherapy
- ☐ Kidney trouble / Dialysis
- ☐ Eye Disease /Glaucoma/Contact lenses
- ☐ Delay in healing
- ☐ Malignant hyperthermia
- ☐ Infectious mononucleosis
- ☐ Hepatitis A, B, C, D, E
- ☐ STD/HIV/AIDS
- ☐ Blood transfusion
- ☐ Anemia or hemophilia
- ☐ Pain & clicking of jaws when eating
- ☐ Other Medical Issues not listed

Is it possible that you are currently pregnant? Y/N If Yes, how many weeks_____
Are you nursing? Y/N
Are you currently taking birth control medication? Y/N

Dr. Signature: _____

MEDICATION & ALLERGIES

Are you taking any kind of medicine, drugs, or pills? (Prescp. or OTC) Y/N

_____

_____

Are you currently taking, or have taken, Bone Density medication i.e. Bisphosphonates?
Ex: Fosamax, Actonel, etc.

_____

Have you ever had any negative reaction to local anesthetic? Y/N
Are you allergic to or have you ever had an adverse reaction to:

Codeine	Y/N	Penicillin	Y/N
Aspirin	Y/N	Tetracycline	Y/N
Latex	Y/N	Sulfa	Y/N

Other medications you are allergic to: _____

_____ _____ _____
Patient or Guardian Signature Printed Name Date

Phone:_____ Email: _____

We reserve the right to charge a $40 fee for a missed appointment or a cancellation with less than a 24 hour notice.

Dr. Dorothy Paul, DDS

Oral Screening Consent Form

Our practice continually looks for advances to ensure that we are providing the optimum level of oral health care to our patients. We are concerned about oral cancer and look for it in every patient.

One American dies every hour from oral cancer. Late detection of oral cancer is the primary cause that both the incidence and mortality rates of oral cancer continue to increase. As with most cancers, age is the primary risk factor for oral cancer. Tobacco and alcohol use are other major predisposing risk factors but **more than 25% of oral cancer victims have no such lifestyle risk factors.**

We have recently incorporated Velscope® into our oral screening standard of care. Velscope® is similar to proven early detection procedures for other cancers such as mammography, Pap smear, and PSA. Velscope® is a simple and painless examination that gives the best chance to find any oral abnormalities at the earliest possible stage. Early detection of pre-cancerous tissue can minimize or eliminate the potentially disfiguring effects of oral cancer and probably save your life. The Velscope® exam will be offered to you annually.

Here is a brief overview of what a cancer screening examination is like:

Initially, Dr. Paul will perform a regular visual examination of the mouth. This includes the glands, tongue, cheeks and palate as well as the teeth. The Velscope® projects a blue light inside the mouth. During the procedure you will be asked to wear protective glasses. Lesions and other indicators of oral cancer are easily noticeable because they appear much darker under the specialized light.

This enhanced examination is recognized by the American Dental Association code revision committee as CDT-5 procedure code D0431; however, this exam might not be covered by your insurance. **The fee for this enhanced examination is $30.00**.

Yes. I authorize the clinician to perform the oral cancer screening. I accept financial responsibility for this enhanced examination if my insurance company does not currently cover this procedure.

Print Name:_____

Signature:_____ Date:_____

No. I would prefer not to have an oral cancer screening at this time.

Print Name:_____

Signature:_____ Date:_____