STEWART | HEFTON
DENTISTRY

PATIENT REGISTRATION

First Name:_____ Last Name:_____ Middle Initial:_____

Patient is:
- ☐ Policy Holder
- ☐ Responsible Party

Preferred Name:_____

Patient Information

Address: _____ Address 2:_____
City: _____ State / Zip: _____ _____
Home Phone: _____ Work Phone: _____ Cellular: _____
Sex: Male Female Marital Status: Married Single Divorced Separated Widowed
Birth Date: _____ Age: _____ Soc. Sec. _____ Drivers Lic: _____
Email: _____ I would like to receive correspondences via e-mail: Yes / No

Employment Status: Full Time Part Time Retired
Student Status: Full Time Part Time

Emergency Contact: _____ Referred By: _____
Emergency Contact Phone: _____ Previous Dentist: _____
Preferred Pharmacy: _____ Pharmacy Phone: _____

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____
Address: _____ Address 2:_____
City: _____ State / Zip: _____ _____
Home Phone: _____ Work Phone: _____ Cellular: _____
Birth Date: _____ Soc. Sec. _____ Drivers Lic: _____

Primary Insurance Information:

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other
Insured Soc. Sec: _____ Insured Birth Date: _____
Employer: _____ Employer Phone: _____
Insurance Company: _____ Insurance Phone: _____
Insurance ID: _____ Insurance Group#: _____

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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.

Please circle yes or no:

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 explain: _____
Have you ever pre-medicated with an Anti-biotic for dental treatment?	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	
Do you use controlled substances?	Yes	No	

Women: Are you
Pregnant/Trying to get pregnant? Yes No
Taking oral contraceptives? Yes No
Nursing? Yes No

Men: Have you taken any ED medication in the last 24 hours?
in the last 24 hours? Yes No

Are you allergic to any of the following? (Please circle all that apply)

Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa Drugs Other

If any apply, please explain: _____

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

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

Have you ever had any serious illness not listed above? If so, 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_____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. If you sign a Consent Form, we may use and disclose your medical records only for each of the following purposes: treatment, payment and healthcare operations.

Treatment means providing, coordinating, or managing healthcare and related services by one or more healthcare providers. An example of this would include teeth cleaning services.
Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment. Healthcare operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information. We may, without prior consent, use or disclose protected health information to carry out treatment, payment, or healthcare operations in the following circumstances:

In emergency treatment situations, if we attempt to obtain such consent as soon as reasonably practicable after the delivery of such treatment; If we are required by law to treat you, and we attempt to obtain such consent but are unable to contain such consent; or If we attempt to obtain your consent but are unable to do so due to substantial barriers to communicating with you, and we determine that, in our professional judgment, your consent to receive treatment is clearly inferred from the circumstances.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it. The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations. The right to inspect and copy your protected health information. The right to amend your protected health information. The right to receive an accounting of disclosures of protected health information. The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. This notice is effective as of October 17, 2002 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office. You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

- ☐ I do NOT authorize any information to be discussed with any family members or friends.
- ☐ I authorize information about treatment or appointments to be discussed with the following person(s):

_____

I have read and understand the above information.

_____ _____

Patient Signature Date

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INFORMED CONSENT FOR GENERAL DENTAL PROCEDURES

You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to the treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with accurate information before, during, and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

Please read and initial the items below and sign at the bottom of the form.

1. Treatment to be provided

I understand that during my course of treatment that the following care may be provided:

X Examinations	X Restorations	X Crowns
X Preventive Services	X Bridges	X Other

Patient Initials _____

2. Drugs and Medications

I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues; pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).
Patient Initials _____

3. Changes in Treatment Plan

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary.
Patient Initials _____

4. Dental Insurance

I give my permission to the dental office to bill my dental insurance provider for the treatment provided, if applicable.
Patient Initials _____

_____ _____

Patient Signature Date

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BILLING PROCESS

Once you provide the office with your dental insurance, we call to verify your benefits. The information we receive from your insurance company is only an estimation of coverage and not a guarantee. We will file your claim to the insurance company directly, after you have been treated in our office. If the insurance company does not cover the estimated amount in full, you will receive a statement in the mail and be responsible for the remaining account balance.

I have read and understand the billing process at Stewart|Hefton Dentistry.

_____
Patient Name (Print)

_____ _____
Patient Signature Date

PRACTICE POLICIES

We strive to provide quality dental care in a timely manner. In order to do so we have had to implement a cancellation and no show policy. The policy enables us to better utilize available appointments for our patients in need of dental care.

CANCELLATION OF AN APPOINTMENT Please be courteous and call our office promptly if you are unable to attend an appointment. This time could be filled by a patient in urgent need of care. We ask that you make an attempt to call 24 hours in advance.

NO SHOW POLICY A "no show" is an appointment that was not canceled in advance. No shows inconvenience other patients who need dental care. A no show for a scheduled appointment will result in a fee of $50 for every half hour scheduled.

LATE ARRIVALS We ask that you are on time for your scheduled appointment. In the event you are running late, please call the office. If you are more than 15 minutes late to your scheduled appointment, you may be asked to reschedule.

I have read and understand the "Practice Policies".

_____
Patient Name (Print)

_____ _____
Patient Signature Date