DeForest DENTAL

New Patient Registration Form – Welcome to Our Practice!

Patient Name:_____
Last *First* *MI*

Preferred Name:_____ Gender: ☐ Male ☐ Female Family Status: ☐ Married ☐ Single

DOB:_____/_____/_____ Social Security #:_____-_____-_____ ☐ Child ☐ Other

Email Address:_____ Cell Phone:_____

Home Phone:_____ Work Phone:_____ Best Time to Call:_____

Address:_____
City *State* *Zip*

Whom may we thank for referring you to our practice?_____

In Case of Emergency, who should be notified:_____
Name *Phone*

Primary Dental Insurance:

Name of Subscriber:_____
Last *First* *MI*

Subscriber's DOB:_____/_____/_____ Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Subscriber's Address_____
(If different from Patient) *City* *State* *Zip*

Ins. Plan Name:_____ Phone:_____

Subscriber ID #:_____ Group #:_____ Employer:_____

If you have a Secondary Dental Insurance, please give us your card/info

Insurance Authorization:

☐ By Checking this box I: authorize my insurance to pay my benefits directly to the dentist for all services rendered
authorize the use of electronic signature on all insurance submissions
authorize the dentist to release all information necessary to secure the payment of benefits
understand that I am financially responsible for all charges, whether or not paid by insurance

Dental Information:

How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Are your teeth sensitive? ☐ Yes ☐ No If yes, describe:_____

How many times a day do you brush?_____ Floss?_____ Do your gums bleed when you brush or floss? ☐ Yes ☐ No

Have you had periodontal (gum) treatments? ☐ Yes ☐ No Have you had orthodontic treatment? ☐ Yes ☐ No

Do you use any other dental cleaning aids? (electric toothbrush, waterpik, water flosser, soft picks)? ☐ Yes ☐ No
*List:*_____

Name of previous Dentist:_____ Date of last exam:_____

Date of most recent x-rays:_____

Physician Information:

Name of Physician:_____ Phone #:_____

Date of most recent physical exam:_____

Medical History: Indicate which of the following you have had or presently have. Checking the box will indicate a "YES" response, leaving blank will indicate a "NO" response.

☐ Allergies-Seasonal	☐ Chemotherapy	☐ Heart Valve Replacement	☐ Persistent Heartburn
☐ Allergy-Latex	☐ Chronic Pain	☐ Hepatitis	☐ Pre-diabetic
☐ Allergy-Penicillin/Amoxicillin	☐ Congestive Heart Failure	☐ High Blood Pressure	☐ Radiation Treatment
☐ Allergy-Sulfa	☐ Depression/Anxiety	☐ High Cholesterol	☐ Respiratory Problems
☐ Allergy-Other	☐ Diabetes	☐ HIV/AIDS	☐ Rheumatic Fever
☐ Anemia	☐ Dizziness	☐ Irregular Heartbeat	☐ Seizures
☐ Arthritis	☐ Eczema	☐ Jaundice	☐ Shingles
☐ Artificial Joints	☐ Epilepsy	☐ Kidney Disease	☐ Sinus Problems
☐ Asthma	☐ Excessive Bleeding	☐ Liver Disease	☐ Sleep Apnea
☐ Autoimmune Disease	☐ Fainting	☐ Low Blood Pressure	☐ Stomach Problems
☐ Back Surgery	☐ Fibromyalgia	☐ Mental Disorders	☐ Stroke
☐ Blood Disease	☐ Frequent Headaches	☐ Migraines	☐ Thyroid Problems
☐ Blood Transfusion	☐ Glaucoma	☐ Mitral Valve Prolapse	☐ Tonsillitis
☐ Bruise Easily	☐ Head Injuries	☐ Nervous Disorders	☐ Tuberculosis
☐ Cancer	☐ Heart Attack	☐ Osteoporosis	☐ Tumors
☐ Cardiovascular Disease	☐ Heart Disease	☐ Pacemaker	☐ Ulcers
☐ Other_____	☐ Iodine Allergy	☐ TMJ/Jaw Pain	☐ Use Tobacco Products

☐ Have you ever been hospitalized? ☐ Taking dietary supplements ☐ Subject to frequent headaches?
☐ Taking medication for weight control (ie: fen-phen?) ☐ Use tobacco products (smoking, chew, e-cigarette/vape)
☐ Presently being treated for any other illness? ***FEMALE ONLY***: ☐ Pregnant ☐ Taking birth control pills

Do you take PREMEDICATION for your dental visits? If yes, please explain:_____

List any medications, supplements, or vitamins you are taking (or give us a paper copy of your meds list):

_____

_____

_____

Describe any medical treatment, impending surgery, or other treatment that may affect your dental treatment:

_____

☐ By checking this box, I acknowledge that the above information is correct and I understand it is my responsibility to inform the office of any changes in my health as soon as possible.

_____

Signature *Date*

DeForest Dental
HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgment & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.
MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

_____ _____
Please ***print*** name of Patient Please ***sign*** for Patient / Guardian of Patient

_____ _____
Legal Representative / Guardian Relationship of Legal Representative / Guardian

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes spouses, step-parents, grandparents and any caretakers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

- ☐ Cell Phone Confirmation
- ☐ Home Phone Confirmation
- ☐ Work Phone Confirmation
- ☐ Text Message to my Cell Phone
- ☐ Email Confirmation
- ☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

- ☐ Cell Phone Confirmation
- ☐ Home Phone Confirmation
- ☐ Work Phone Confirmation
- ☐ Text Message to my Cell Phone
- ☐ Email Confirmation
- ☐ **Any of the Above**

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

Privacy Officer Name and Contact Number: Kristy Denk - 608-846-3948 Email: kdenk@deforestsmiles.com

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment _____
I could not communicate with the patient _____
The patient refused to sign _____
The patient was unable to sign because _____

Other (please describe) _____

Signature of Privacy Officer_____

X-Ray/Records Release Form

Please complete and email/mail to your previous dental provider if you would like any records or x-rays transferred to our office.

Date:_____

Please send all current records, including bitewing x-rays taken within the last 24 months, full series or panoramic x-ray taken within the last 5 years, and any other pertinent dental records to:

DeForest Dental
637 W. North St.
DeForest, WI 53532
info@deforestsmiles.com

I/we have an appointment scheduled on:_____

Print Name Date of Birth

Other family members

Address

City State Zip

Signature