St. Luke's Family Dentistry

# PATIENT REGISTRATION

**Patient Information** Date:_____

First Name_____ Last Name _____ Middle Initial_____

Address_____

City, State, Zip_____

Home Phone_____ Work Phone_____ Cell_____

Birth Date_____ Sex: M___ F___ Soc. Sec_____ Driver's Lic. #_____

Email_____

**Employer**

Name of Employer_____

Address_____

City, State, Zip_____

**Primary Insurance Information**

Name of Insured_____ Relationship to Insured_____

Insured Soc. Sec_____ Insured Date of Birth _____

Insurance Company_____ Insurance Phone_____

Insurance I.D. #_____ Group Number _____

**Secondary Ins. Company**_____ Insurance phone_____

**Responsible Party (If someone other than the patient)**

First Name_____ Last Name _____ Middle Initial_____

Address _____

City, State, Zip_____

Home Phone_____ Work Phone_____ Cell_____

Birth Date_____ Sex: M___ F___ Soc. Sec_____ Driver's Lic. #_____

# 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 explain: _____

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

Do you use controlled substances? ◯ Yes ◯ No

Women: Are you

☐ Pregnant/Trying to get pregnant? ☐ Nursing?

☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Sulfa Drugs

☐ Other If yes, please explain: _____

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

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

Have you ever had any serious illness not listed above? ◯ Yes ◯ No 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 _____

**HIPAA Authorization for Release of Protected Health Information**
**for its Dental Practice Customers**
**("Authorization")**

By signing this Authorization, you agree to the release of your Protected Health Information as described in this Authorization. This Authorization is intended to comply with the requirements of the HIPAA Privacy Rule. If you have questions about this Authorization, please contact the Privacy Official, noted below. If you agree with this Authorization, please complete it, sign and date it at the end and provide to us.

**Our Dental Practice contact information:**

| | |
|---|---|
| Dental Practice Name: | St. Luke's Family Dentistry |
| Privacy Official for Dental Practice: | Dr. Sandra Wasif |
| Dental Practice mailing address: | 100 Burnsed Place Ste. 1000, Oviedo, FL 32765 |
| Dental Practice phone number: | 407-366-9090 |

**Your contact information (please complete):**

| | |
|---|---|
| Patient name: | |
| Mailing address: | |
| Patient email address: | |
| Patient phone number: | |

**Protected Health Information that I am authorizing the Dental Practice to release (please check the records to which this Authorization applies):**

I authorize the Dental Practice named above to release the following Protected Health Information:

___ Dental report(s)

___ Dental image(s)

___ Other (specify) _____

Patient or Guardian signature:_____ Date:_____

**The reason for the release of the Protected Health Information (please check the reason(s) that apply):**

___ Payment for care, including insurance ___ Patient Request

___Other(specify):_____

**I am requesting that the Dental Practice release my Protected Health Information to (please complete):**

| | |
|---|---|
| Organization name: | |
| Person name & relationship: | |
| Mailing address: | |
| Phone number: | |
| Fax number: | |
| Email address: | |
| When your Protected Health Information is released as provided in this Authorization, the recipient may not have a legal obligation to protect its confidentiality and may redisclose it. | |

**Expiration of this Authorization:**This Authorization will automatically expire one year after the date that I sign it unless I (_____) indicate an earlier date or event here: _____.

**Your rights with respect to this Authorization:** It is completely your decision whether or not to sign this Authorization. We cannot refuse to treat you if you choose not to sign this Authorization. If you sign this Authorization, you can revoke it prior to the expiration date above by sending a note in writing to **St. Luke's Family Dentistry** at **100 Burnsed Place Ste. 1000, Oviedo,Fl 32765.** The revocation will not have any effect, however, on actions taken in reliance on the Authorization prior to your revocation. **BY MY SIGNATURE, I CERTIFY THAT I HAVE READ AND UNDERSTAND THIS AUTHORIZATION. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY PROTECTED HEALTH INFORMATION AS DESCRIBED IN THIS AUTHORIZATION.**

_____ _____

Patient or Guardian's signature Date

Authority of Personal Representative to Sign for Patient (check one):

□ Parent □ Guardian □ Power of Attorney □ Other:_____


**ACKNOWLEDGEMENT OF RECEIPT OF**
**HIPAA NOTICE OF PRIVACY PRACTICES**
**("Acknowledgement")**

I acknowledge that I have received a copy of St. Luke's Family Dentistry's **HIPAA Notice of Privacy Practices**.

_____
Patient Name (Please Print)

_____ _____
Patient Signature or Personal Representative — Date

Authority of Personal Representative to Sign for Patient (check one):

□ Parent □ Guardian □ Power of Attorney □ Other: _____

**Please Note: It is your right to refuse to sign this Acknowledgement.**

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*Dental Office Use Only*

I tried to obtain written Acknowledgement by the individual noted above of receipt of our **Notice of Privacy Practices**, but it could not be obtained because:

__ An emergency prevented us from obtaining acknowledgement.

__ A communication barrier prevented us from obtaining acknowledgement.

__ The individual was unwilling to sign.

__ Other:_____

_____ _____
Staff Member Signature — Date

100 Burnsed Place , Suite 100, Oviedo,  FL, 32765

**FINANCIAL STATEMENT AND AUTHORIZATIONS**

**Please Print Name: _____ Date: _____**

**I authorize payment of dental benefits to the attending Dentist for services, however I understand that I am fully responsible for all professional fees and expenses incurred.  If my dental insurance carrier does not pay a portion of my bill, I agree to immediately pay the entire remaining balance.**

**It is the policy of this practice that full payment (including co-pays, deductibles and patient percentages) is due at the time services are rendered.  We are happy to accept your payment by cash, check, Visa, MasterCard, Discover, American Express and Debit Card.  We will submit claims to those insurance companies with which we have a contract, however it is the sole responsibility of the insured to know the type of insurance and reimbursement.  Any balances that are over 90 days past due will have the credit reporting agencies notified and be turned over to a collections agency unless previous arrangements have been made.**

**Remember, you and/or your employer pay the insurance  premiums.  Your insurance company is accountable to you, not us.  Do not hesitate to contact them if you disagree with their payment or to find out the status of your claim.**

**Signature _____**

**General Consent Form**

I give permission to members of the staff of St. Luke's Family Dentistry to provide me with an examination and digital X-rays, as needed. This will include an evaluation of my teeth for decay, my gums for detachment and/or gum disease, and an oral cancer screening. As a result of this examination additional care may be recommended. The following will provide information about the dental procedures that are most often recommended to our patients.

**Cleaning**: Most people expect to receive an examination by the dentist, along with x-rays and a cleaning. In some cases, it may be determined that a patient has gum disease or infection for which a cleaning would be inappropriate and could be harmful. We will inform you if you may need a cleaning after we have provided you with a thorough examination and evaluation of your teeth and gums.

**Fillings, post and core buildups, crowns, extractions or dental surgeries, root canal treatment, implants, TMJ treatment, periodontal treatment or any other dental treatment performed may be followed by some or all of the following:**

- Damage to adjacent teeth or fillings
- Damage to teeth due to perforations, separated endodontic instruments or any other complications
- Allergic reaction to a product or metal used
- Post-operative discomfort, swelling, bleeding or infection which may require additional visits or treatment
- Delayed healing of an extraction site requiring additional days to heal or additional care
- Bruising, swelling, sensitivity, infection, dry socket or pain
- Sinus infection, inflammation or perforation of the sinus. This may require treatment or surgical repair at a later date
- Nerve involvement resulting in prolonged numbness, burning or tingling of the lip, tongue, chin or other areas
- Complication during treatment which may require the intervention and or referral to a specialist.
- Restricted mouth opening, closing, bruising, or lip chapping or cracking, all of which may last several weeks
- Sensitivity of newly filled teeth due to inflammation of the nerves. This usually heals within several days. However, in some of the cases the inflammation and sensitivity may not go away and may require a root canal to relieve the sensitivity or pain. Very deep decay and/or fillings increase the probability that you will need a root canal. We use special desensitizing solutions under our fillings to help prevent these occurrences

- Patient's Name:_____ Patient/Guardian's Signature:_____

**Dental Anesthetics:** All medications including local anesthetics bear a small risk of reactions/infection at the site of the injection. Even fewer may experience prolonged numbness of anesthetized areas, sometimes lasting more than one year.

If other procedures are recommended or required, our staff will be happy to go over the benefits and risks with you and provide you with additional written information.

Although we will have made recommendations for your oral health care that we believe will provide you with long-term benefits, you always have the choice to refuse care. Before you make this choice, please be sure to ask our staff about the likely consequences. In this way, you will be able to make a more informed decision.

I have read and I understand the contents of this document. If I had any questions, a member of St. Luke's Family Dentistry has answered them to my satisfaction. I also understand that payments for services are due and payable at the time I receive those services. My responsibility will be explained to me as treatment is recommended.

Patient/Guardian Name Signature Date

_____ _____ _____

Witness Name Signature

_____ _____