Karen C. Reid, D.M.D

PATIENT REGISTRATION AND MEDICAL HISTORY

Patient ID: _____ Blood Pressure:_____

Patient Name:_____ Sex: ☐Male ☐Female Age:_____

Address:_____

Apartment#_____ City:_____ State:_____ Zip Code:_____

Phone Number:_____ Email: _____ Date of Birth:___/___/_____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed S.S.#_____

Employed by:_____ Occupation:_____

Business Address:_____

Business Phone:_____ Spouse Name:_____

Spouse Employed by:_____ Occupation:_____

Business Address:_____

Who is responsible for this account?_____ Relationship to Patient:_____

In case of emergency, who should be notified?_____ Phone#_____

Whom may we thank for referring you?_____

Medical History

Physician's Name:_____ Date of last physical: ____/____/_____

Reason for today's visit:_____

Date of last Dental Visit:____/____/_____

Does patient have any physical or mental conditions? ☐ Yes ☐ No

If yes, specify_____

Has patient had any surgeries? ☐ Yes ☐ No

If yes, specify_____

Does patient have any heart problems? ☐ Yes ☐ No

If yes, specify_____

Has patient ever been told by a doctor that he/she needs to take antibiotics before any dental treatment?

☐ Yes ☐ No

Does patient has asthma or any respiratory problem? ☐ Yes ☐ No

Does patient have a history of convulsions? ☐ Yes ☐ No

Has patient tested positive for Hepatitis or HIV? ☐ Yes ☐ No

If yes, specify_____

_____

Does patient have any allergies to: Medications ☐ Yes ☐ No

Latex ☐ Yes ☐ No

Other _____

Specify reaction:_____

Is patient currently taking any medication? ☐ Yes ☐ No

If yes, specify_____

If patient is female, is patient pregnant? ☐ Yes ☐ No

Does patient have any condition not listed above? ☐ Yes ☐ No

If yes, specify_____

_____

Does patient need special assistance to communicate, i.e. Braille, TTY, Sign Language

☐ Yes ☐ No

What is patient's native language? _____

If patient is 18 or older does patient have a living will? ☐ Yes ☐ No

I certify that I have read and understand the above. All questions have been answered to the best of my ability. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. I also consent to initial exam and any necessary x-rays.

Patient/Guardian Signature:_____ Date:_____/_____/_____

Insurance Information

Primary Insurance

Subscriber First/Last Name: _____

Insurance Carrier: _____

Member ID: _____ Group #: _____

Telephone #: _____

Secondary Insurance

Subscriber First/Last Name: _____

Insurance Carrier: _____

Member ID: _____ Group #: _____

Telephone #: _____

Preferred Pharmacy

Pharmacy Name: _____

Address OR Cross streets: _____

_____

Telephone #: _____

PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.
- **Additional Uses:** Additionally we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting or treatment rooms. We may use your health information to call you to remind you of, cancel or re-schedule an appointment. We may leave a message on your answering machine, telephone, voice mail or electronic mail/message. We may mail appointment reminders, announcement or greeting cards to your home. Your name or picture may be used on a "Thank You for Referring", "Welcome to Our Office", "Testimonials", "Office Bulletin Board" and or "Website" unless you specifically request us not to do so.

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____ day of _____, 20___.

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____

STATEMENT OF PATIENT FINANCIAL RESPONSIBILITY

Patient Name: _____ **DOB:** _____

Riviera Dental appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your doctor elects to continue past your approved period, you will be responsible for your balance in full.

I have read the above policy regarding my financial responsibility to Riviera Dental, for providing dental services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Riviera Dental, the full and entire amount of bill incurred by me or the above named patient; if applicable any amount due after payment has been made by my insurance carrier.

Patient Signature _____ **Date** _____

Guarantor Signature _____ **Date** _____

Statement of Financial Responsibility – Self Pay

Patient Name: _____ **DOB:** _____

I do not have dental insurance and will be responsible for services rendered here at Riviera Dental. I agree to pay Riviera Dental, the full and entire amount of treatment given to me or to the above named patient at each visit.

Patient/Guarantor Signature _____ **Date** _____