PATIENT REGISTRATION for Dental Clinic

Patient Information: Today's date_____

Name _____ Birth date _____

If prefer another name _____

Address _____ City _____ State ___ Zip _____

Home Phone _____ Cell Phone _____

Male _____ Female _____ Marital Status _____

Employer _____ Employer Phone No. _____

Employer Address _____

Spouse's Name _____ Spouse's Birth date _____

Emergency Contact name _____ Phone No. _____

Best way to contact you: _____ Cell phone _____ Home phone ____ Text

_____ Email If yes, email address _____

Parent/Guardian Information if patient is child under 18:

Name of Parent/Guardian _____ Birth date _____

Relationship to patient _____ Phone No. _____

Insurance Information:

Primary Insurance (please provide card to copy)

Name of Insured _____ Employer _____

Name of Dental Insurance Co. _____

Member No._____Group No. _____

Address to send claims to _____

Secondary Insurance (please provide card to copy)

Name of Insured _____ Employer _____

Name of Dental Insurance Co. _____

Member No. _____Group No. _____

Address to send claims to _____

Policies

Appointment Reminders:

We may call, text, or write to remind you of scheduled appointments, or that it is time to make a routine appointment. *Unless you tell us otherwise, we will mail you an appointment reminder, and/or leave you a reminder message including the date of appointment, time of appointment and name of the patient on the mailbox of the phone number or the address you have given us. Please keep us up to date of any phone number and/or address changes.*

Appointment Cancellation/Broken Policy:

Due to the large number of people who make appointments but fail to show up for them or fail to give adequate notice when cancelling them, it has become necessary to have a policy on appointment responsibility. **An appointment is considered broken or missed if the patient fails to show up for the appointment, if the patient appears more than 10 minutes late for a scheduled appointment, or if the patient calls to cancel an appointment with too little advance notice to allow that appointment time to be rescheduled with another patient.** After the FIRST missed appointment there may be a waiting period before scheduling a second appointment. A SECOND failed appointment may prevent you from receiving dental treatments in our clinic. You will receive notification by mail if we find it necessary to take this action. We reserve the right to decide if this policy can be waived for special situations. No action will be taken against patients who have cancelled their appointments at least 24 hours in advance.

Dental Room Policy:

A parent or guardian is allowed with a child who is 18 years of age or under. Due to the limited space in the dental rooms we request that all patients over the age of 18 please be seen alone unless a special request has been granted by the attending dentist. No more than 1 person may accompany someone else during a dental treatment such as an extraction or filling. Safety of your family is a concern of the health department so unless a child is being seen by the dentist or hygienist we request he/she stay in the waiting room with another adult. *We also ask that all cell phones be turned off during procedures and no foul language be used*.

Special Needs:

Please make us aware of any special needs you or your child may have. We will try to accommodate your needs within reason to make your visit to the dental clinic as worry-free as possible. Examples include: wearing headphones during procedures, having extra back support in the chair, changing the music station. Ultimately treatment will depend upon the cooperation level of you or your child. If we are unable to provide you with treatment, we will provide you with your insurance phone number to call or a list of other providers.

Restorations (Fillings):

Please be aware that care must be exercised in chewing on fillings in order to avoid breakage or soft tissue damage. Also, a more extensive filling than originally diagnosed may be required due to additional decay. Sensitivity may occur after a newly placed filling and may last for several weeks. It is the discretion of the dentist to use a silver colored filling (amalgam) or a white colored filling (composite) for durability reasons for posterior (back) teeth. Front teeth will always have white colored fillings.

Possible complications from procedures:

Complications resulting from the use of dental instruments, drugs, sedation, medicines, analgesics (pain killers), anesthetics, and injections include (but are not limited to) swelling, sensitivity, bleeding, pain, infection, numbness and tingling sensation in the lip, tongue, chin, gums, cheeks, and teeth (which is transient but on infrequent occasion, may be permanent), reactions to injections, changes in occlusion (biting), jaw muscle cramps or spasms, temporomandibular (jaw) difficulty, referred pain to ear, neck, and head, nausea, vomiting, allergic reactions, delayed healing and treatment failure.

X-rays and photos:

Modern dental x-ray equipment is extremely low-dose radiation. Diagnostic x-rays provide the Dental staff with valuable information about your teeth and supporting bone that cannot be evaluated otherwise. If you request an x-ray be sent by email to another provider, we will do all we can to protect your information; however, we do not use encrypted email so a risk still remains. If you request, a copy can be printed instead for you to pick up.

Dismissal from the Dental Clinic:

Patients may be dismissed from the practice at the discretion of the Dewitt-Piatt Bi-County Health Dept. Dental Clinic staff. Reasons for dismissal include, but are not limited to:

- *More than 2 times, being more than 15 minutes late to an appointment.*
- *More than 2 times, failure to give a 24-hour advance notice to cancel a scheduled appointment.*
- *Refusal to cooperate and work with the dental staff.*
- *Threatening, inappropriate or rude behavior*
- *Failure to pay an outstanding balance.*

Payment for Services Including patients with Dental Insurance or Medicaid:

- We accept most major dental insurance plans along with Illinois Medicaid, IL State All Kids Program and their associated managed care companies. A patient will be required to bring his/her current Medicaid and insurance cards to each visit.
- Not all benefits covered by the Medicaid card or private insurance companies are offered by our practice. A referral may be needed for further treatment.
- All of a patient's dental needs may not be covered by the Medicaid card or private insurance, either because it is not a benefit or because of benefit limitations. Our office has no control over what is covered or not by insurance. <u>The patient is financially responsible for all services that are received that are not covered by the Medicaid card or private insurance and full payment is expected at the time of service.</u>
- <u>Private pay</u> -- Our dental clinic provides a range of dental services to all patients on a sliding-fee scale based on household income. All private pay patients will need to bring proof of income for all members of the household who will be included on the sliding-fee account. <u>Payment in full is required at the time of service.</u>
- Patients with an outstanding balance for dental work provided will not be seen until all balances are paid in full. Absolutely no exceptions will be made.
- All insurance co-pays and patient portions are due at the time of service.

Consent for Services

By signing this form I agree to the following:

- To allow the dental staff of DeWitt-Piatt Bi-County Health Department Dental Clinic to proceed with and perform any exams, x-rays, dental cleanings, restorations, and treatments as explained to me and found to be necessary for my (my child's) care.
- That I have the right to ask questions before any procedure for myself or my child.
- To follow all policies as dictated by the DeWitt-Piatt Bi-County Health Department in the section entitled "Policies."
- That I understand that dentistry is not an exact science and that any treatment plan provided will be an estimate of care and subject to modification depending upon unforeseen or undiagnosable circumstances that may arise during the course of treatment.
- That I understand that after payment or non-payment by my dental insurance I am responsible for all non-covered fees for myself or my child as legal guardian. I, agree to pay any collection fees, or court costs that may be incurred to satisfy this obligation.

_____ _____

Patient, Parent or Legal Guardian's Signature *Date*

Authorization for Release of Records

I authorize the DeWitt-Piatt Bi-County Health Dept. Dental Clinic to release my or my child's information including diagnosis and the records of treatment to my or my child's insurance company in order to receive payment or for referral of services to another specialty provider. I authorize the DeWitt-Piatt Bi-County Health Dept. Dental Clinic to release my or my child's information including diagnosis and the records of treatment to my or my child's health practitioners or specialists for best treatment of care.

I authorize the DeWitt-Piatt Bi-County Health Dept. Dental Clinic to release my or my child's information including diagnosis and the records of treatment to the following people either by phone or in person. For my child I allow the following person(s) to serve as a proxy when bringing my child for appointments by allowing decisions to be made without my presence for preventive and restorative procedures only: (Please include spouse since we cannot release information without this consent.)

_____ Relationship: _____

_____ Relationship: _____

_____ Relationship: _____

_____ _____

Patient, Parent or Legal Guardian's Signature *Date*

Notice of Privacy Practices and Disclosures

I, also hereby acknowledge that I received or was offered a copy of the "Notice of Privacy Practices" from DeWitt-Piatt Bi-County Health Dept. Dental Clinic dated April 14th, 2003, revised March 7, 2018.

_____ _____

Patient, Parent or Legal Guardian's Signature *Date*

Dental and Medical History Information

Please understand that it is important that you release any information about your medical history to your dentist. 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. It is important that you inform us of any medications that you are taking each time that you come to an appointment, as some medications can cause harmful reactions with dental anesthetics, analgesics, antibiotics, etc. Please be sure to provide us with a list of any drug allergies you may have. Thank you!

Patient Name: _____ **Date of Birth**: _____

Dental History:

Please list dental concerns _____

Are you in pain? _____Yes _____No Where:_____

Sensitive to Hot? _____Yes _____No Sensitive to Cold? _____Yes _____No

Brush daily? _____Yes _____No Floss daily? _____Yes _____No

Gums ever bleed? _____Yes _____No Loose/moveable teeth? _____Yes _____No

Clench/grind? _____Yes _____No Popping/clicking in jaw? _____Yes _____No

Wear a partial? _____Yes _____No Periodontal disease? _____Yes _____No

Estimated date of last dental visit _____

Medical History:

Please list the name of your primary care/family doctor _____

Have you ever been hospitalized or had a major operation? _____ Yes _____ No

If yes, what for: _____

Have you ever had a serious head or neck injury? _____ Yes _____ No

Have you ever had a joint replacement (hip, knee, wrist) or an artificial heart valve?

_____ Yes _____ No Type: _____ Year:_____

Has your doctor ever recommended you pre-medicate with antibiotics before dental work?

_____ Yes _____ No Reason: _____

Have you ever taken Fosamax, Boniva, or any other bisphosphonates?_____ Yes _____ No

If you are on a special diet, please list the type: _____

Do you smoke, vape or use smokeless tobacco? If yes, list type/amount? _____

Are you taking oral contraceptives? _____ Yes _____No (Antibiotics may change effectiveness)

Are you pregnant? _____ Yes _____ No If yes, due date: _____

Are you currently taking any blood thinners such as Coumadin, Warfarin, Plavix or a low dose Aspirin? _____ Yes _____ No If yes, type: _____

PLEASE FLIP OVER TO COMPLETE MEDICAL HISTORY

Current Medications: (a copy can be made of any lists)

_____

_____

_____

Allergies:

____Acrylic ___Amoxicillin/Penicillin ____Aspirin ____Codeine
____Food Dyes ___Ibuprofen ____Latex ____Local Anesthetics
____Metal ___Sulfa Drugs ____Tramadol

List any other allergies: _____

Do you have, or have you had, any of the following? (Please check those that apply)

____AIDS/HIV Positive
____Anemia
____Arthritis
____Attention Disorder (ADHD/ADD)
____Blood Disease
____Bruise Easily
____Congenital Heart Disorder
____Depression
____Drug Addiction
____Eating Disorder
____Excessive Bleeding
____Frequent Cough
____Frequent Heartburn/GERD
____Heart Murmur/Irregular heartbeat
____Hemophilia/Bleeding disorder
____Hepatitis C
____High Cholesterol
____Kidney Problems
____Liver Disease
____Lupus
____Oppositional Defiance Disorder
____Parathyroid Disease
____Prolonged use of Corticosteroids
____Renal Dialysis
____Sensory Processing sensitivity/disorder
____Shingles
____Sjogren's Syndrome
____Swelling of Limbs
____Tuberculosis

____ Alzheimer's Disease/Dementia
____ Angina/Chest pain
____ Artificial Heart Valve
____Autism
____Blood Transfusion
____Cancer
____Convulsions
____Diabetes
____Dry Mouth
____Emphysema
____Excessive Thirst
____Frequent Diarrhea
____Glaucoma
____Heart Pacemaker
____Hepatitis A
____Herpes
____Hives/Rash
____Leukemia
____Low Blood Pressure
____Mitral Valve Prolapse
____Osteoporosis
____Post-Traumatic Stress Disorder (PTSD)
____Radiation/Chemotherapy
____Rheumatoid Arthritis
If yes, to: __Noises __Smells __Sounds __Tastes
____Sickle Cell Disease
____Stomach/Intestinal Disease
____Thyroid Disease
____Tumors or growths

____Anaphylaxis
____ Anxiety
____Asthma
____Autoimmune Disease
____Breathing problems
____Cold Sores/Fever Blisters
____Crohn's Disease
____Dizziness
____Easily Winded
____Epilepsy or Seizures
____Fainting spells
____Frequent Headaches
____Heart Attack/Failure
____Heart Trouble/Disease
____Hepatitis B
____High Blood Pressure
____Hypoglycemia
____Liquid Iron Supplements
____Lung Disease
____MRSA
____Pain in Jaw Joints/TMD
____Recent Weight Change
____Scarlet Fever
____Sinus Trouble
____Stroke
____Tonsillitis
____Ulcers

Any other illnesses:_____

_____

Signature: _____ Date completed: _____