Patient Registration Form

Rodney E. Burdette, D.D.S. & Jason J. Peacock D.D.S., M.S.

Patient Name_____Date_____

Date of Birth_____

Referred By? _____

Address_____

Home Telephone_____work_____

E-mail address_____

Social Security #_____

Employer_____

Employer Address_____

How Long? _____

Insurance Company_____

Address_____

Telephone_____

Group Name_____

Group Number_____

_____

OFFICE POLICY

You are entitled to and will receive the best dental care that we can provide. To help maintain these standards, we feel that you should have a clear understanding of our office policy. Our appointment schedule is maintained to respect the value of your time and ours. Your prompt arrival will prevent delays for others.
If you need to change an appointment, we request <u>at least</u> 48 hours notice.

If you do not have insurance payment will be expected at the time service is rendered. For your convenience, we accept cash, checks, MasterCard, Visa, Discover, or American Express. We are also able to offer financing for most of our patients, the details of which can be discussed per your request.

We will work with all major dental insurance carriers and ask that you bring your insurance information to your appointments. You will be expected to pay your estimated copayment at the time of service. All estimated copayments are based on the information you and your insurance carrier provide us. Please understand that your insurance does not guarantee coverage and you will be responsible for any portion that they do not cover.

We are accepting new patients and appreciate your kind referrals. Thank You!

SIGNATURE_____DATE_____

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Here at River View Dental Associates we are constantly learning and striving to advance the standards of our patient care in our office. As such, adding a new procedure to your routine hygiene care to help fight periodontal disease.

Periodontal disease affects approximately 80% of adults and is growing epidemic in our society. Understanding of this disease has increases greatly over the last few years. We now know that periodontal disease is a bacterial infection in the pockets around teeth. As such, we now not only treat periodontal disease with removal of mechanical irritants and disease tissue (your normal cleaning) but are also addressing the underlying infection that causes it. With that thought in mind we recommend that all of our patients have their teeth decontaminated prior to cleaning appointments for three major reasons.

1. To reduce or eliminate bacteremia's. During the normal cleaning process most patients will have some areas that may bleed. This allows bacteria that are present in all of our mouths to flood into the blood stream and sometimes settle in the weakened areas of our body such as a damaged heart valve or artificial knee or hip, etc. We pre-medicate those clients that we know have a heart condition or artificial joints with antibiotics so that these bacteria can't cause harm to these areas. Latest research shows that these oral pathogens have now been linked to a number of other diseases such as cardiovascular disease, rheumatoid arthritis, low birth weight babies, diabetes, etc. Needless to say anything that we can do to reduce or eliminate these bacteremias is a plus for our clients.
2. To prevent cross contamination of infection in one area of your mouth to other areas. Decontamination minimizes the chance that we may inadvertently pick up bacterial infection in one area of our mouth and move it to others.
3. To eliminate periodontal disease bacteria and stop their infections before they cause physical destruction or loss of attachment around your teeth.

The laser decontamination process is painless and normally takes about 5-10 minutes. We highly recommend that you take advantage of this service as part of your routine hygiene visit. The hygienists, Joan and Lee, Certified Laser Periodontal Therapists, are available to answer any questions regarding this treatment.

Laser decontamination is $41 and is not typically covered by insurance. It is our experience that insurance coverage lags behind the leading edge in high tech health care. You have certain rights and responsibilities as the insured and informing your insurance carrier of the benefits of this treatment will help to facilitate a demand for this type of coverage.

- ☐ Yes, I am interested and would like to discuss this further at my first visit
- ☐ Not interested at this time

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MEDICAL HISTORY **NAME: _____ DATE: _____**

Could you tell us about your current medical condition and medical history?

_____

_____

Physician: _____ Phone # _____

Are you presently under a doctor's care? _____ for?_____
Date of last physical? _____
Have you been hospitalized or have a history of serious illness? _____
for:_____

Have you been advised to take antibiotics or other medication prior to dental care? ___
If yes, what have you been prescribed? _____
Do you have a history of :
artificial heart valves? _____ artificial joints? _____ congenital heart defect? ___

Allergies: medications? ____ local anesthesia? ___ Latex? ____seafood? ___ Other?

_____

Blood pressure _____/_____ (this will be taken during your initial visit)

Please indicate if you have now or have had any of the following:

__ heart condition
__ pacemaker
__ anemia
__ blood problems
__ blood transfusion
__ excess bleeding (cut or extraction)
__ stroke
__ fainting or dizzy spells
__ epilepsy
__ neurological problems
__ hearing problems
__ eye problems
__ glaucoma
__

__ thyroid difficulties
__ diabetes
__ kidney disease
__ ulcers
__ colitis
__ liver problems
__ hepatitis
__ tuberculosis
__ lung disease
__ asthma
__ breathing problems
__ cancer
__ radiation treatment
__ chemotherapy
__ smoke or use tobacco

__ allergies
__ hay fever
__ sinus problems
__ shingles
__ fever blisters
__ herpes
__ frequent headaches
__ alcohol abuse
__ drug dependency
__ psychiatric or emotional problems
__ HIV+, AIDS
__ sexually transmitted disease
__ pregnant? what month? ____
__ other _____

MEDICATIONS: (over the counter or prescribed) **REASON:**

_____

_____

HERBS , VITAMINS, SUPPLEMENTS? Self? **Provider? _____**

_____

_____

SIGNATURE:_____

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DENTAL HISTORY

Tell us about your **previous dental experiences?**

What would you like **us to know** in order to work effectively with you?

What things have you experienced in the past that you would like to find in **this practice?**

What are the main **issues, challenges, problems** you would like us to help you with?

What **changes** have you noticed in your dental condition?

What would you hope would **stay the same** in your mouth?

What could we do to help you have a **healthier** mouth?

How do you **care for your teeth and gums** at home?

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Are you **aware** of or **concerned** about any of the following dental issues?

Y N

☐ ☐ Do your gums bleed?

☐ ☐ Have you ever had trauma to your lower face?

☐ ☐ Have you ever been diagnosed with or treated for TMJ problems?

☐ ☐ Has your jaw ever locked open or closed?

☐ ☐ Do you grind or clench your teeth ? Day or night?

☐ ☐ Do you experience headaches? How often?

☐ ☐ Are any of your teeth sensitive to hot, cold or sweets?

☐ ☐ Are any of your teeth loose?

☐ ☐ Do you have any areas of roughness in your mouth?

☐ ☐ Do you have any areas where food gets caught in or around your teeth?

☐ ☐ Are you aware of any unusual odor or taste in your mouth?

☐ ☐ Have you noticed any chipped or worn edges on your teeth?

☐ ☐ Are you aware of any discoloration or stain on your teeth?

☐ ☐ How do you feel about the alignment or spacing of your teeth?

☐ ☐ Have you ever had any oral surgery? Extractions?

☐ ☐ Have you ever had orthodontics?

☐ ☐ Have you ever had a head injury?

☐ ☐ Have you ever had any injury to your mouth?

☐ ☐ Have you ever had periodontal surgery?

Are there **any other concerns** we did not cover that you have regarding your oral health?

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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 (HIPAA). 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. insurance company);
- The day-to-day healthcare operations of your practice

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 HIPAA. 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 requ3st 4restrictions 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 agree, you are then bound to comply with this restriction.

I understand that I may revoke tis 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: _____