Patient Registration Form

Patient Information

Date of Appointment 2018-11-28

Patient`s First Name: bjklb	Middle Name: sdfsdfs	Last Name: dfsdfsdfs	
Sex: $sex	Maritial Status: sdfsdf	Date of Birth: 2018-11-15	Social Security Number: sdfsfdsdf
Patient`s Address: vpo sonkra tehsil nilokheri - dist-karnal	City: Daman and Diu	State: Georgia	Zip: 132116
Home Phone: (423) 423-4234	Mobile Phone: (423) 423-4234	Email Address: asdadasda@gmail.fdgsd	
Referred by: sdfsfsdfsdf			

Patient Employer/School Information

Employer/School: sdfsdfs	Occupation: fsdfsdf	Employer/School Phone: (423) 423-4234	
Employer/School Address: vpo sonkra tehsil nilokheri - dist-karnal	City: Daman and Diu	State: Georgia	Zip: 132116

Emergency Contact Information

Emergency Contact Name: fsdf	Emergency Contact Phone: (423) 423-4234	Relation to Patient: kljpiojpjhpoj[poju[poju[opju

Name: fsdf Gender: Age: Date of Appointment

Reason for visit

What brings you to the office?
ty jtry tyju ytuyt

Allergies

Are you allergic to any of the following?

Adhesive Tape ✓ Antibiotics ✓ Latex ✓

Barbiturates ✓ Aspirin ✓ Iodine ✓

Codeine ✓ Sulfa ✓ LocalAnesthetics ✓

Do you have any other allergies?
lpokpojojpjpj

Name:	Reaction:
Name:	Reaction:

Current Medication

Care you currently taking any blood thinners?

Yes No

What medications are you currently taking?

Name: fsdf sdfsdfs dfsdfsdfs	Dosage: hioho	Frequency: hoihioh	Reason: iohioh	Date: 2018-11-23
Name: fsdf sdfsdfs dfsdfsdfs	Dosage: ioh	Frequency: oih	Reason: sdfsdfsdsd	Date: 2018-11-23
Name: fsdf sdfsdfs dfsdfsdfs	Dosage: ihiohio	Frequency: ioh	Reason: ihpiohiohoih	Date: 2018-11-23

Hospitalizations &Surgeries

Dental History

When was your last dental exam?

Date: 20
18-11-08

When were your last dental x-rays taken?

Date: 20
18-11-22

How often do you brush?

#times/day:
sdfsdfsdfs

How often do you floss?

#times/day:
dfsfdsdfsdf

Do you grind your teeth?

Yes

No✓

Have you ever had orthodontic (braces) treatment?

Yes✓

No

Have you ever had periodontal (gum) treatments?

Yes✓

No

Do you have any of the following?

Bad Breath ✓
Bleeding Gums ✓
Blisters on Mouth ✓
Broken Fillings ✓
Clicking Jaw ✓
Dentures ✓
Difficulty Opening or Closing ✓
Dry Mouth ✓
Difficulty Chewing ✓
Ear Pain ✓
Jaw Pain ✓
Loose Teeth ✓
Mouth Pain ✓
Mouth Sores ✓
Partials ✓
Sensitivity to Cold ✓
Sensitivity to Heat ✓
Sensitivity to Sweets ✓
Sensitivity to Pressure ✓
Swollen Gums ✓

Past Medical History

Have you ever had any of the following?

Alcoholism ✓
Allergies ✓
Anxiety Disorder ✓
Arthritis ✓
Asthma ✓
Aids Hiv ✓
Bleeding Disorder ✓
Blood Disease ✓
Blood Transfusion ✓
Bowel Disorder ✓
Cancer ✓
Diabetes ✓
Depression ✓
Eating Disorder ✓
Epilepsy ✓
Hay Fever ✓
Heart Disease ✓
Heart Problem
Hepatitis-A, B or C ✓
High Blood Pressure ✓
High Cholesterol
Joint Disorder ✓
Kidney Disorder ✓
Liver Disorder
Lung Disease ✓
Lupus ✓
Measles ✓
Migraines ✓
Osteoporosis ✓
Pacemaker ✓
Rheumatic Fever ✓
Sinus Problems ✓
Skin Disorder ✓
Stroke ✓
Stomach Ulcer ✓
Substance Ab
Thyroid Disorder
Tuberculosis ✓
Venereal Disease ✓

Lifestyle Factors

Yes✓

No

Do you use recreational drugs?

Yes✓

No

Type?:
jklpjhpjhpo

#times/week:
kjjhpiojhp

How much alcohol do you drink per week?

#drinks/week: pojpopojpo

How much caffeine do you drink per day?

Have you ever smoked?

Yes

No

#times/day:
kp'[kp

# of years:
;lm'pkp'k

Do you smoke now?

Yes✓

No

Women Only

Are you pregnant?

Yes

No✓

Are you breastfeeding?

Yes

No✓

What is your method of birth control?

#drinks/day: pojpojpo fgdfgdfgdg

A Statement of Financial Policies for our Patients

First, please allow us to welcome you to our office. We hope to make your visit as pleasant as possible. Unfortunately, aside from the emotional and physical impact of any dental treatment, there is all too often a degree of financial impact as well. We would like to erase your potential financial burden as much as possible. Your review of our financial policies at this time will help greatly to avoid future misunderstanding and make everyone`s job that much easier.

1. Our relationship and our contract with you is that of Dentist-Patient. We do not provide dental services to insurance companies and have no responsibility to assure that the insurance company is pleased with your dental care.

2. Any contract that exists between you and your insurance company for dental care reimbursement does not obligate us to comply with the provision of your policy. We will assist you in the filing of your claims. Our ultimate responsibility is for the correct filing and processing of insurance paperwork. However, all other inquires remain with you and your insurance company. Please ask them; do not depend on us to be familiar with all the different types of insurance plans.

3. We do not file for medical coverage with your insurance under any circumstances.

4. We take a $50 deposit for scheduling any major treatment. Deposits taken goes towards the treatment that is done on the appointment day.Payment is expected at time of service for all procedures not covered by your insurance.

5. Often the insurance companies will use the term "usual and customary" or similar language when denying charges for dental care. The implication is that the doctor charges too much for a given procedure or visit. Universal "usual and customary" fee schedules do not exist. The amount an insurance company reimburses for a procedure will vary with the company, the type, and the quality of a policy. Our fee schedule is the same for everyone. The only time there is a variation in charges is when there exists a contract between an insurance company and us to provide care at a discount in exchange for qualifying as a "participating provider-dentist"

6. In the event of default, patient’s guarantor will be responsible for all collections cost, including attorney and court fees. Quality, personalized dental care is sometimes necessarily quite expensive. Despite the pressure to pass along increased cost to the patient, we work hard on your behalf to contain fees and other charges. We are here to serve you for your dental care needs. If we have done well, please tell your family and friends. If not, tell us!

I have read and understood the above. I have kindly been given a copy of this document for my records.

Signed

Date

HIPAA Patient Consent Form

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patient`s consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal dental records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect that privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal dental records as provided by the Georgia Code. We may have indirect treatment relationships with you (such as laboratories that only interact with doctors and not patients), and may have to disclose personal health information for purposes of treatment, payment or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we

have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Patient/Parent/Guardian`s Name

Print Patient/Parent/Guardian`s Name

Missed Appointment Policy

We feel the doctor/patient relationship is built on mutual trust and respect. As such, we strive to be on time for your scheduled appointments, and ask that you give us the same courtesy. However, we understand that unforeseen circumstances occasionally occur and you will be unable to keep your scheduled appointment.

If you are unable to keep your scheduled appointment, we require a 24-hour notice (1-full business day) so that we may accommodate the dental needs of another patient. This guideline applies to both visits with our hygienist and our doctors. **If an appointment is cancelled or rescheduled within 24 hours of the reserved appointment time, Riverwood Dental may charge the patient the following nominal fees:**

$45.00 for first missed appointment

$75.00 for second missed appointment

Hygiene Visits: All patients will receive the opportunity to miss one scheduled appointment. A $30 fee will be charged to the patient account for any additional late- cancel/failed appointments.

If 2 appointments are broken without proper advance notice, we may be unable to schedule additional appointments for you.

I have read the above notification, and I understand its implications to my account with Riverwood Dental. I assume full responsibility for making and keeping my own appointments. Furthermore, I assume any charges that may be assessed to my account when I violate the above stated policy.

Name :

Date :

Signature :