PATIENT REGISTRATION

PERSONAL INFORMATION

Patient Name *(First, Middle Initial, Last)* **:**		**Date:**
Preferred Name:		**Gender:** ☐ **Male** ☐ **Female**
Date of Birth:	**SSN:**	**Employed By:**
Email Address:		
Preferred Pharmacy:	**Pharmacy Location:**	
Home #:	**Cell #:**	**Work #:**
Mailing Address:		
City:	**State:**	**Zip Code:**
Spouse's Name:	**DOB:**	**Phone #:**

DENTAL INSURANCE INFORMATION

****PLEASE HAND DENTAL INSURANCE CARD(S) TO RECEPTIONIST TO MAKE A COPY FOR YOUR FILE****

☐ **Insurance is the same as past appointment(s)**	☐ **I do NOT have dental insurance**
Policy Holders Name:	**Relationship to Patient:** ☐ Self ☐ Dependent ☐ Spouse
Policy Holders DOB:	**Policy Holders SSN:**
Policy Holders Phone #:	**Policy Holder's Employer:**
INS Company:	**INS Phone #:**
Group #:	**Member ID:**

EMERGENCY CONTACT/CARE GIVER

****If someone brings patient to appointments or if we would be contacting someone in regards to appointments, please note them here****

Name:	**Phone #:**	**Relationship:**

MEDICAL HISTORY

Physician's Name:	**Phone #:**
Please check any of the following which you have had or currently have:	☐ **NONE OF THESE CONDITIONS APPLY**

☐ **Artifical Joints** (*list what joints and month/year of surgery*)

☐ A-Fib	☐ Alzheimer	☐ Anemia	☐ Arthritis	☐ Artificial Heart Valves
☐ Asthma	☐ Back Problems	☐ Blood Disease	☐ **Blood Thinners**	☐ Cancer
☐ Chemical Dependency	☐ Codeine Allergy	☐ Diabetes	☐ Dizziness/Fainting	☐ Epilepsy
☐ Excessive Bleeding	☐ Glaucoma	☐ Head Injuries	☐ Heart Murmur	☐ Heart Problems
☐ Hepatitis	☐ Herpes	☐ High Blood Pressure	☐ HIV/AIDS	☐ Kidney Disease
☐ **Latex Allergy**	☐ Liver Disease	☐ Low Blood Pressure	☐ Mental Disorders	☐ Mitral Valve Prolapse
☐ Nervous Disorders	☐ Osteoporosis	☐ Pacemaker	☐ **Penicillin Allergy**	☐ Pregnant/Nursing
☐ **PREMED**	☐ Prolonged Bleeding	☐ Psychiatric Care	☐ Radiation Treatment	☐ Respiratory Problems
☐ Rheumatism	☐ Seizures	☐ Sinus Problems	☐ Stomach Problems	☐ Stroke
☐ Sulfa Allergy	☐ Tuberculosis	☐ Tumors	☐ Ulcers	☐ Veneral Disease

Do you have any drug allergies? *(please list)*

Please list any medications you are taking? *(if excessive, please give list to receptionist)*

Please list any other important information about your medical history here:

PLEASE FLIP OVER FOR SIGNATURE ON BACK 

PATIENT REGISTRATION

CONSENTS

I hereby certify the above information is correct and true. I will not hold Dr. Cox and/or Dr. Von Gunten responsible for any errors or omissions that I may have made in the completion of this form.

PAYMENT FOR DENTAL SERVICES MUST BE MADE AT THE TIME THEY ARE RENDERED. We accept cash, personal checks, Visa, MasterCard, Discover and Care Credit.

1. The undersigned hereby authorizes doctor to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by the doctors to make a thorough diagnosis of the patient's dental needs.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment.
3. Lastly, **I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered** (unless other arrangements have been made ahead of time). In the event payments are NOT received at time of service, I understand that a 1-1/2% finance charge may be added to my account.

DENTAL INSURANCE

ASSIGNMENT OF BENEFITS	RELEASE OF INFORMATION
I authorize payment of dental benefits to myself or the named provider for professional services rendered.	I authorize the release of any dental information necessary to process this claim.

HIPAA CONSENT

I give permission to *Dr. Cox and/or Dr. Von Gunten* to disclose my health, treatment and diagnostic records (this includes all past, present and future period of health care information) with the following:

1. _____ Relation to patient: _____
2. _____ Relation to patient: _____
3. _____ Relation to patient: _____
4. _____ Relation to patient: _____
5. _____ Relation to patient: _____

I understand that the information used or disclosed under the Authorization From may be subject to re-disclosure by the person(s) or facility receiving it and would then no longer be protected by federal privacy regulations.

I have the right to refuse to sign this Authorization Form. If signed, I have the right to revoke this authorization, in writing, at any time. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

Signature of Patient: _____ Date: _____