PATIENT REGISTRATION

ID: _____ Chart ID: _____ Date: _____

First Name: _____ Last Name: _____ Middle Initial: _____

Patient Is: ◉ Policy Holder ○ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Address 2: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Extension: ____ Cell Phone: _____

Birth Date: _____ SS #: _____ Driver's License #: _____

○ Responsible Party is also a Policy Holder for Patient ◉ Primary Insurance Policy Holder ○ Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Extension: ____ Cell Phone: _____

Sex: ◉ Male ○ Female Marital Status: ◉ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth Date: _____ Age: _____ SS #: _____ Driver's License #: _____

Email: _____ ☐ I would like to receive correspondences via email.

Employment Status: ○ Full Time ○ Part Time ○ Retired Employer: _____

Student Status: ○ Full Time ○ Part Time Medical Hx Changes: _____

Medicaid ID: _____ Preferred Dentist: _____ Emergency Contact: _____

Carrier ID: _____ Preferred Hygienist: _____ Emergency #: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured SS#: _____ Insured Birth Date: _____

Employer: _____ Insurance Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Rem. Benefits: _____ Rem. Deduct: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ◉ Self ○ Spouse ○ Child ○ Other

Insured SS#: _____ Insured Birth Date: _____

Employer: _____ Insurance Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Rem. Benefits: _____ Rem. Deduct: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Please list any health problems you may have or medications you are taking.

Are you under a physician's care now?	◉ Yes	○ No	If yes: _____
Have you ever been hospitalized or had a major operation?	○ Yes	○ No	If yes: _____
Have you ever had a serious head or neck injury?	○ Yes	○ No	If yes: _____
Are you taking any medications, pills, or drugs?	○ Yes	○ No	If yes: _____
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes	○ No	If yes: _____
Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates?	○ Yes	○ No	If yes: _____
Are you on a special diet?	○ Yes	○ No	If yes: _____
Do you use tobacco or a vape?	○ Yes	○ No	If yes: _____
Do you use controlled substances?	○ Yes	○ No	If yes: _____

Women: Are you…

○ Pregnant / Trying to get pregnant? ◉ Nursing? ○ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal
☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◉ Yes ○ No	Emphysema ○ Yes ○ No	Irregular Heartbeat ○ Yes ○ No	Swelling of Limbs ○ Yes ○ No	
Alzheimer's Disease ○ Yes ○ No	Epilepsy or Seizures ○ Yes ○ No	Kidney Problems ○ Yes ○ No	Thyroid Disease ○ Yes ○ No	
Anaphylaxis ○ Yes ○ No	Excessive Bleeding ○ Yes ○ No	Leukemia ○ Yes ○ No	Tonsillitis ○ Yes ○ No	
Anemia ○ Yes ○ No	Excessive Thirst ○ Yes ○ No	Liver Disease ○ Yes ○ No	Tuberculosis ○ Yes ○ No	
Angina ○ Yes ○ No	Fainting Spells / Dizziness ○ Yes ○ No	Low Blood Pressure ○ Yes ○ No	Tumors or Growths ○ Yes ○ No	
Arthritis/Gout ○ Yes ○ No	Frequent Cough ○ Yes ○ No	Lung Disease ○ Yes ○ No	Ulcers ○ Yes ○ No	
Artificial Heart Valve ○ Yes ◉ No	Frequent Diarrhea ○ Yes ○ No	Mitral Valve Prolapse ○ Yes ○ No	Venereal Disease ○ Yes ○ No	
Artificial Joint ○ Yes ○ No	Frequent Headaches ○ Yes ○ No	Osteoporosis ○ Yes ○ No	Yellow Jaundice ○ Yes ○ No	
Asthma ○ Yes ○ No	Genital Herpes ○ Yes ○ No	Pain in Jaw Joints ○ Yes ○ No		
Blood Disease ○ Yes ○ No	Glaucoma ○ Yes ○ No	Parathyroid Disease ○ Yes ○ No		
Blood Transfusion ○ Yes ◉ No	Hay Fever ○ Yes ○ No	Psychiatric Care ○ Yes ○ No	Have you ever had any serious illness not listed above?	
Breathing Problems ○ Yes ○ No	Heart Attack / Failure ○ Yes ◉ No	Radiation Treatments ○ Yes ○ No		
Bruise Easily ○ Yes ○ No	Heart Murmur ○ Yes ○ No	Recent Weight Loss ○ Yes ○ No		
Cancer ○ Yes ○ No	Heart Pacemaker ○ Yes ○ No	Renal Dialysis ○ Yes ○ No	◉ Yes ○ No	
Chemotherapy ○ Yes ○ No	Heart Trouble / Disease ○ Yes ○ No	Rheumatic Fever ○ Yes ○ No		
Chest Pains ○ Yes ○ No	Hemophilia ○ Yes ○ No	Rheumatism ○ Yes ○ No	If yes:	
Cold Sores / Fever Blisters ○ Yes ○ No	Hepatitis A ○ Yes ○ No	Scarlet Fever ○ Yes ○ No		
Congenital Heart Disorder ○ Yes ○ No	Hepatitis B or C ○ Yes ○ No	Shingles ○ Yes ○ No		
Convulsions ○ Yes ○ No	Herpes ○ Yes ○ No	Sickle Cell Disease ○ Yes ○ No		
Cortisone Medicine ○ Yes ○ No	High Blood Pressure ○ Yes ○ No	Sinus Trouble ○ Yes ○ No		
Diabetes ○ Yes ○ No	High Cholesterol ○ Yes ○ No	Spina Bifida ○ Yes ○ No		
Drug Addiction ○ Yes ○ No	Hives or Rash ○ Yes ○ No	Stomach / Intestinal Disease ○ Yes ○ No		
Easily Winded ○ Yes ○ No	Hypoglycemia ○ Yes ○ No	Stroke ○ Yes ○ No		

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian:

_____ Date: _____

PATIENT CONSENT - ADULT

Clinical

1. I authorize Owens Family & Cosmetic Dentistry to perform all recommended treatment, including but not limited to:
    a. All recommended treatment;
    b. Radiographs, study models, photos, and other diagnostic aids or materials (collectively, "Diagnostic Material") as needed to make a thorough diagnosis;
    c. The use of anesthetics, nitrous oxide, sedatives, and other medication, as needed, and am fully aware that using anesthetic agents involves certain risks, including but not limited to redness and swelling of tissues, pain, itching, vomiting, dizziness, miscarriage, cardiac arrest, drowsiness, and/or lack of coordination.

Financial

2. I am responsible for payment for all services rendered. Should my account become delinquent, I will be responsible for all additional collection costs, including reasonable attorney fees.

Maintaining Appointments

3. A $50 missed appointment fee could be charged to my account for missed appointments or last-minute cancellations by me. I am aware that a 24-hour notice of cancellation is required.

Insurance

4. I authorize the practice to submit claims for payment for services rendered or pre-authorizations necessary to my insurance company, on my behalf and in my name listed as "signature on file," and assign to the practice the insurance benefits providing assignment is accepted. I am responsible for payment regardless of coverage provided.
5. I am responsible for providing any insurance changes, should they occur, prior to treatment.

HIPAA Acknowledgement

6. I authorize the practice to release to staff, hospitals, health care services plans, insurance companies, self-insurers or their representatives, specialty dentists involved in my care, any and all information, records, and other diagnostic material about my medical history, services rendered, or recommended treatment.
7. I acknowledge receipt of the Notice of Privacy Practices and authorize the practice to use and disclose my protected health information for any clinical financial, and insurance purposes.
8. I authorize sharing my protected health information with the following individuals who may be involved in my care and I understand I am responsible to notify the practice of any changes:
    a. Name: _____ Relationship/Phone #: _____
    b. Name: _____ Relationship/Phone #: _____
    c. Name: _____ Relationship/Phone #: _____
9. I authorize the following means of communication:

    Home #: _____ to include a message

    Mobile #: _____ to include a text message and voice message

    Email: _____ Other: _____

Patient (Over 18) Signature: _____ ***Date:*** _____

☐ Individual Refused to Sign

PATIENT CONSENT - MINOR CHILD

(Effective until age 18 - Tennessee)

The parent or legal guardian must complete this form for a minor, provide consent for dental treatment, and accompany the child during each dental visit. Treatment will not be provided for unattended minors unless it is an emergency. If you wish to designate another adult to be a decision-maker in your child's dental care, please complete the Limited Power of Attorney. If you authorize sharing protected health information, complete the HIPAA Acknowledgement section below.

Your Child(ren)'s Names:

Patient's Name _____ DOB: ____/____/____

Patient's Name _____ DOB: ____/____/____

Patient's Name _____ DOB: ____/____/____

Patient's Name _____ DOB: ____/____/____

Clinical

1. As the parent/legal guardian of the child(ren) listed above, I authorize Owens Family & Cosmetic Dentistry to perform all recommended treatment, including but not limited to:
    a. All recommended treatment;
    b. Radiographs, study models, photos, and other diagnostic aids or materials (collectively, "Diagnostic Material") as needed to make a thorough diagnosis;
    c. The use of anesthetics, nitrous oxide, sedatives, and other medication, as needed, and am fully aware that using anesthetic agents involves certain risks, including but not limited to redness and swelling of tissues, pain, itching, vomiting, dizziness, miscarriage, cardiac arrest, drowsiness, and/or lack of coordination.

Financial

2. I am responsible for payment for all services rendered. Should my account become delinquent, I will be responsible for all additional collection costs, including reasonable attorney fees.

Maintaining Appointments

3. A $50 missed appointment fee could be charged to my account for missed appointments or last-minute cancellations by me. I am aware that a 24-hour notice of cancellation is required.

Insurance

4. I authorize the practice to submit claims for payment for services rendered or pre-authorizations necessary to my insurance company, on my behalf and in my name listed as "signature on file," and assign to the practice the insurance benefits providing assignment is accepted. I am responsible for payment regardless of coverage provided.
5. I am responsible for providing any insurance changes, should they occur, prior to treatment.

HIPAA Acknowledgement

6. I authorize the practice to release to staff, hospitals, health care services plans, insurance companies, self-insurers or their representatives, specialty dentists involved in my care, any and all information, records, and other diagnostic material about my medical history, services rendered, or recommended treatment.
7. I acknowledge receipt of the Notice of Privacy Practices and authorize the practice to use and disclose my protected health information for any clinical financial, and insurance purposes.
8. I authorize sharing my protected health information with the following individuals who may be involved in my care and I understand I am responsible to notify the practice of any changes:
    a. Name: _____ Relationship/Phone #: _____
    b. Name: _____ Relationship/Phone #: _____
    c. Name: _____ Relationship/Phone #: _____
9. I authorize the following means of communication:
    Home #: _____ to include a message
    Mobile #: _____ to include a text message and voice message
    Email: _____ Other: _____

Patient (Over 18) Signature: _____ ***Date:*** _____

☐ Individual Refused to Sign