CENTER SQUARE
FAMILY DENTAL
NISHIT SHAH, DMD

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www.CenterSquareDental.com

Adult Registration and Medical History

Your complete oral health is our main concern. Communication is key to helping us give you a happy, healthy smile. We therefore ask that you complete this form in its entirety.

1 About You

Today's Date: _____

E-mail Address: _____

Name: _____
LAST FIRST MI MR MRS MS DR

I prefer to be called: _____ ❑ Male ❑ Female

Birthdate: __/__/__ Age: _____ SS #: _____

Home Address: _____
APT / CONDO #

_____
CITY STATE ZIP

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Home #: (___)_____ Pager/Cell #: _____

Work #: (___)_____ Ext: _____ DL #: _____

Employer: _____

Employer's Address: _____

How long there? _____ Occupation: _____

Where and when are best times to reach you? _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

Previous/Present Dentist: _____

Last Visit Date: _____

2 Spouse Information

Name: _____

Employer: _____

Work #: (___)_____ Ext: ____ SS #: _____

Birthdate: __/__/__ DL #: _____

Person Responsible for Account:

Work #: (___)_____ Ext: ____ Home #: (___)_____

Billing Address: _____

Relation: _____ SS #: _____

Employer: _____ DL #: _____

3 Dental Insurance

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (___)_____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: __/__/__ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (___)_____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: __/__/__ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

I hereby assign payment of dental benefits otherwise payable to me directly to Center Square Family Dental, LLC.

Signature: _____

In the event of an emergency, is there someone who lives near you that we should contact?

Name: _____ Relation: _____

Work #: (___)_____ Home #: (___)_____

4 Medical History

Do you have a personal physician? ❑ Yes ❑ No

Physician's Name: _____

Phone #: (___)_____ Date of last visit: _____

Are you currently under the care of a physician? ❑ Yes ❑ No

Please Explain: _____

4 MEDICAL HISTORY continued

Your current physical health is: ❑ Good ❑ Fair ❑ Poor

Are you taking any prescription, over-the-counter, or supplement drugs? ❑ Yes ❑ No

Please list each one: _____

_____

Do you smoke or use tobacco in any other form? ❑ Yes ❑ No

Have you ever taken Fosamax, Actonel, Boniva, or any other bisphosphonate? ❑ Yes ❑ No

Are you using a prescribed method of birth control? ❑ Yes ❑ No

Are you pregnant? ❑ Yes ❑ No Week #: _____

Are you nursing? ❑ Yes ❑ No

Have you ever had any of the following diseases or medical problems? (Please circle option that applies)

Y N	Anemia/Radiation Treatment	Y N	Hemophilia/Abnormal Bleeding
Y N	Artificial Bones/Joints/Valves	Y N	Hepatitis
Y N	Arthritis	Y N	High/Low Blood Pressure
Y N	Asthma	Y N	HIV+/AIDS
Y N	Blood Transfusion	Y N	Hospitalized for Any Reason
Y N	Cancer/Chemotherapy	Y N	Kidney Problems
Y N	Congenital Heart Defect	Y N	Mitral Valve Prolapse
Y N	Diabetes	Y N	Psychiatric Problems
Y N	Difficulty Breathing	Y N	Rheumatic/Scarlet Fever
Y N	Drug/Alcohol Abuse	Y N	Severe/Frequent Headaches
Y N	Emphysema/Glaucoma	Y N	Shingles
Y N	Epilepsy/Seizures/Fainting Spells	Y N	Sickle Cell Disease/Traits
Y N	Fever Blisters/Herpes	Y N	Sinus Problems
Y N	Heart Attack/Stroke	Y N	Tuberculosis (TB)
Y N	Heart Murmur	Y N	Ulcers/Colitis
Y N	Heart Surgery/Pacemaker	Y N	Venereal Disease

Please list any serious medical condition(s) that you have ever had:

_____

_____

Are you allergic to any of the following?

Y N	Aspirin	Y N	Erythromycin	Y N	Penicillin
Y N	Codeine	Y N	Jewelry/Metals	Y N	Tetracycline
Y N	Dental Anesthetics	Y N	Latex	Y N	Other

Please list any other drugs/materials that you are allergic to: _____

_____

5 DENTAL HISTORY

Why have you come to the dentist today?

_____

_____

Do you require antibiotics before dental treatment? ❑ Yes ❑ No

Are you currently in pain? ❑ Yes ❑ No

Have you ever had a serious/difficult problem associated with any previous dental work? ❑ Yes ❑ No

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? ❑ Yes ❑ No

Your current dental health is: ❑ Good ❑ Fair ❑ Poor

Do you like your smile? ❑ Yes ❑ No

Are you considering whitening your teeth? ❑ Yes ❑ No

Do your gums ever bleed? ❑ Yes ❑ No

Have you ever had periodontal disease? ❑ Yes ❑ No

How many times a week do you floss?_____ a day do you brush?_____

Type of bristles? ❑ Hard ❑ Medium ❑ Soft

I understand the information I have given today is correct to the best of my knowledge. I also understand this information will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____

Signature Date

Payment is due in full at the time of treatment unless prior arrangements have been approved.

We appreciate your effort to fill out this complete form. It will ensure that we can provide the most effective care possible. Please do not hesitate to ask if you have any questions. We are here for you.

Our office is HIPAA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

OFFICE USE ONLY OFFICE USE ONLY **OFFICE USE ONLY** OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the patient named herein. Initials: Date:

Doctor's Comments: _____

_____

MEDICAL HISTORY UPDATE

1. Date: _____ Comments: _____ Signature: _____

2. Date: _____ Comments: _____ Signature: _____

3. Date: _____ Comments: _____ Signature: _____

CENTER SQUARE
FAMILY DENTAL

Appointment Cancellation Policy

When our office books your appointment, we are saving dedicated chair time just for you. We ask that if you must reschedule your appointment, that you please provide us with at least 48 hours notice. This courtesy makes it possible to give your reserved time slot to another patient.

If you fail to provide sufficient notice to the office or fail to show for your appointment, there will be a $50 charge.

By signing this form, you are agreeing to the terms and conditions of our office appointment cancellation policy.

_____ _____

Patient Signature Date

CENTER SQUARE
FAMILY DENTAL

Our Policy Regarding Dental Insurance

You are fortunate to have dental insurance, whether you have purchased it or your employer has provided it for you. Though your dental insurance is your responsibility, we can help! We will go the extra mile to help you maximize your benefits. As a courtesy, we will help by filing your insurance forms, which will save you considerable time and trouble. We accept payments from most insurance companies, which reduces your immediate out-of-pocket expense.

Regardless of what we may calculate your insurance company to pay, it is only an estimate. Our estimate is based on limited information obtained from your insurance company. You must understand, we cannot forecast what they will pay.

We must stress that **you are responsible for the total treatment fee**. Your dental insurance is not designed to pay the entire cost of your treatment, but it is intended to help cover a certain portion of the cost.

In order for us to obtain your insurance information for submiting your claim and/or discuss your situation directly with your insurance we will need your authorization.

Please Initial:

_____ I have read and understand the above information.

_____ I authorize release of any information relating to my claim.

_____ I authorize payment directly to **Center Square Family Dental, LLC.**

_____ I understand that all fees not paid by insurance are my responsibility.

_____ _____

(Print Name) Date

_____

Signature

CENTER SQUARE
FAMILY DENTAL

Patient Acknowledgment of Receipt of Notice of Privacy Practices

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your health information. In addition, we are required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (04/14/03) and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

_____ _____

(Please Print Name) **Date**

_____

(Signature)

Office Use Only

We attempted to obtain written acknowledgment or receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

Patient Name: _____

- ❑ Individual Refuses to Sign
- ❑ Communication Barriers – prohibited obtaining the acknowledgement.
- ❑ Emergency Situations– prevented us from obtaining the acknowledgement.
- ❑ Other – please explain: _____

_____ _____

Staff Signature **Date**