

WELCOME TO COMFORT DENTAL

PATIENT REGISTRATION & HEALTH HISTORY

*All Comfort Dental Offices are owned & operated by independent, dentist – owned franchises of Comfort Dental Group, Inc.
 Questions or comments about this office should be addressed to the dentists in this practice.
 Comfort Dental Group, Inc. does not own or operate any dental practices.*

PATIENT INFORMATION: MALE FEMALE OTHER

PLEASE PRINT CLEARLY

LAST NAME:		FIRST NAME:		INITIAL:	CELL PHONE:	HOME PHONE:	
MAILING ADDRESS:					CITY:	STATE:	ZIP:
DOB:	AGE:	DL#:	SS#:	EMAIL:			
EMPLOYER:		ADDRESS:			HOW LONG:	WORK PHONE:	
DOB:	AGE:	SCHOOL:			CITY:	GRADE:	

SPOUSE: MALE FEMALE OTHER

LAST NAME:		FIRST NAME:		INITIAL:	CELL PHONE:	HOME PHONE:	
MAILING ADDRESS: <input type="checkbox"/> SAME AS ABOVE					CITY:	STATE:	ZIP:
DOB:	AGE:	DL#:	SS#:	EMAIL:			
EMPLOYER:		ADDRESS:			HOW LONG:	WORK PHONE:	

DENTAL/POLICY HOLDER INFORMATION:

SUBSCRIBER LAST NAME:		FIRST NAME:		INITIAL:	DOB:	SS#:	
INSURANCE NAME:				MEMBER ID:		GROUP #:	
ADDRESS:					CITY:	STATE:	ZIP:
SUBSCRIBER LAST NAME:		FIRST NAME:		INITIAL:	DOB:	SS #:	
ADDITIONAL INSURANCE:				MEMBER ID:		GROUP #:	
ADDRESS:					CITY:	STATE:	ZIP:

Any family members current patients? YES NO

NAME: _____

EMERGENCY CONTACT INFORMATION:

NAME: _____ PHONE #: _____

ADDRESS: _____

RELATIONSHIP TO PATIENT: _____

MEDICAL/DENTAL HISTORY

- Are you experiencing dental pain or discomfort? YES NO
- Are you in good health? YES NO
- Has there been a change in your general health within the past year? YES NO
- Are you under the care of a physician? YES NO
- If so, what condition is being treated? YES NO

Physician's Name: _____ Phone #: _____

DO YOU SMOKE OR USE ANY TOBACCO PRODUCTS? Y N ARE YOU PREGNANT OR THINK YOU MIGHT BE? Y N

PLEASE CHECK ALL THAT APPLY:

- | | | |
|--|--|---|
| <input type="checkbox"/> AIDS (AI) | <input type="checkbox"/> DIABETES (DB) | <input type="checkbox"/> HIVES (HI) |
| <input type="checkbox"/> ALCOHOLISM (AL) | <input type="checkbox"/> DRUG DEPENDENCY (DD) | <input type="checkbox"/> HYPER ACTIVITY (HY) |
| <input type="checkbox"/> ANEMIA (AN) | <input type="checkbox"/> EATING DISORDER (ED) | <input type="checkbox"/> HYPOGLYCEMIA (HG) |
| <input type="checkbox"/> ANGINA (AG) | <input type="checkbox"/> EMPHYSEMA (EM) | <input type="checkbox"/> JAUNDICE (JC) |
| <input type="checkbox"/> ARTIFICIAL HEART VALVE (AV) | <input type="checkbox"/> EPILEPSY (EP) | <input type="checkbox"/> KIDNEY/LIVER DISEASE (KL) |
| <input type="checkbox"/> ARTIFICIAL JOINTS (AJ) | <input type="checkbox"/> FAINTING/DIZZY SPELLS (FD) | <input type="checkbox"/> MITRAL VALVE PROLAPSE (HV) |
| <input type="checkbox"/> ARTHRITIS/RHEUMATISM (AR) | <input type="checkbox"/> FEVER BLISTERS/COLD SORES (FS) | <input type="checkbox"/> NIGHT SWEATS (NS) |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> GAG EASILY (GE) | <input type="checkbox"/> OSTEOPOROSIS (OS) |
| <input type="checkbox"/> BIRTH CONTROL (BC) | <input type="checkbox"/> GLAUCOMA (GL) | <input type="checkbox"/> PARALYSIS (PL) |
| <input type="checkbox"/> BLOOD PRESSURE - HIGH (BH) | <input type="checkbox"/> HEADACHES - FREQUENT (HF) | <input type="checkbox"/> PROLONGED BLEEDING (PB) |
| <input type="checkbox"/> BLOOD PRESSURE - LOW (BL) | <input type="checkbox"/> HEART ATTACK (HA) | <input type="checkbox"/> PSYCHIATRIC TREATMENT (PT) |
| <input type="checkbox"/> BLOOD THINNERS (BT) | <input type="checkbox"/> HEART MURMUR (HM) | <input type="checkbox"/> RHEUMATIC FEVER (RF) |
| <input type="checkbox"/> BRUISE EASILY (BB) | <input type="checkbox"/> HEMOPHILIA (HP) | <input type="checkbox"/> SICKLE CELL DISEASE (SD) |
| <input type="checkbox"/> CANCER (CA) | <input type="checkbox"/> HEPATITIS (H) | <input type="checkbox"/> SINUS TROUBLE (ST) |
| <input type="checkbox"/> CHEMOTHERAPY/RADIATION (CR) | <input type="checkbox"/> HEREDITARY DISEASE/DEFORMITIES (HD) | <input type="checkbox"/> STROKE (SK) |
| <input type="checkbox"/> CONGENITAL HEART DISEASE (GH) | <input type="checkbox"/> HIV POSITIVE (VP) | <input type="checkbox"/> TUBERCULOSIS (TB) |
| <input type="checkbox"/> DEAF | <input type="checkbox"/> HERPES (HR) | <input type="checkbox"/> TUMORS (TM) |
| HAVE YOU HAD ANY OTHER SERIOUS ILLNESS? <input type="checkbox"/> YES <input type="checkbox"/> NO | | <input type="checkbox"/> VENERAL DISEASE (VD) |

EXPLAIN: _____

DRUGS/MEDICATIONS

ARE YOU ALLERGIC TO OR HAVE HAD A BAD REACTION TO?

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> ASPIRIN (AA) | <input type="checkbox"/> IODINE (AD) | <input type="checkbox"/> NARCOTICS (NA) | <input type="checkbox"/> LATEX |
| <input type="checkbox"/> BARBITURATES (AB) | <input type="checkbox"/> KEFLEX (AK) | <input type="checkbox"/> PENICILLIN (AP) | <input type="checkbox"/> OTHER ALLERGIES (Please List) |
| <input type="checkbox"/> CODEINE (AC) | <input type="checkbox"/> LOCAL ANESTHETIC (LA) | <input type="checkbox"/> SULFA (AS) | _____ |
| <input type="checkbox"/> ERYTHROMYCIN (AE) | <input type="checkbox"/> NITROUS OXIDE (NO) | <input type="checkbox"/> TETRACYCLINE (AT) | _____ |

HAVE YOU TAKEN ANY MEDICATION IN THE LAST 6 MONTHS? YES NO PLEASE LIST: _____

PLEASE LIST ANY MEDICATIONS YOU ARE TAKING RIGHT NOW: _____

REASON: _____

Dr Signature: _____

CONSENT: As the undersigned, I hereby authorize Doctor to, after thorough explanation, take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a diagnosis of my dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated (after they are discussed with me) and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at time services are rendered.

All proceeds of insurance are assigned to the doctor when applicable, but without the doctor assuming responsibility for the collection of those claims. If the insurance company does not pay my claim within 60 days after it is mailed, it is understood that I pay the balance of my account and that I contact my insurance company regarding settlement. It is agreed that payment will not be delayed or withheld because of pending insurance coverage.

If I do not pay the entire balance, or if insurance is unpaid after 60 days, a billing charge will be added to my account. The billing charge will be a periodic rate of 1.5% per month (or a minimum charge of \$2.00 for a balance under \$100) which is an annual percentage rate of 18%. In case of default of payment, I agree to pay any and all costs in collecting this account, including but not limited to attorney fees and court costs. I understand that, where appropriate, credit reports may be obtained.

PATIENT/PARENT SIGNATURE: _____ DATE: _____

RELATIONSHIP TO PATIENT: _____ DATE: _____ WITNESS: _____



General Consent

I _____ understand that my treatment plan for today includes the following work listed below I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues, bruising, pain, limited mouth opening, itching, accelerated heart rate, vomiting, and/or anaphylactic shock. I also know that paresthesia numbness is a possible risk of injection that can last permanently or for an indefinite period of time.

I understand that during treatment it may be necessary to change or add procedures because of conditions that were not discovered during examination, but were found while working on the teeth. For example, root canal therapy may be discovered to be needed during routine restorative procedures. I give permission to the dentist to make any/all changes and additions as necessary.

I understand that dentistry is not an exact science and therefore, reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I understand that no other dentist is responsible for my dental treatment.

I hereby authorize any of the doctors or dental auxiliaries to proceed with and perform the dental restorations and treatments explained to me. I understand that this is only an estimate and subject to modification depending on unforeseen or undiagnosable circumstances that may arise during the course of the treatment. I understand that regardless of any dental insurance coverage I may have, I am responsible for payment of dental fees. I agree to pay any attorney's fees, collection fees, or court costs that may be incurred to satisfy this obligation. I confirm that I understand this form and the information contained therein. I am a native speaker of English or have been offered the services of a qualified translator who has explained the information in my native tongue.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____



Authorization to Release & Discuss Dental Information

The HIPPA privacy law requires that we are only authorized to communicate with patients themselves, guardians, insurance providers, and primary care physicians, unless we have authorization in writing by the patient to communicate with others on their behalf. Please provide names of family members or friends you would like to authorize us to release & discuss your dental information. Spouses are not automatically included; their names must be explicitly stated below. You may opt out by checking the "DO NOT RELEASE INFORMATION" box below. I give the following named person(s) authorization to take messages or speak with the office of Comfort Dental - Durango, on my behalf regarding (please check all items authorized):

Name: _____ Relationship: _____

Phone#: _____ Appointments Financial Dental Treatment Insurance

Other (explain): _____

Name: _____ Relationship: _____

Phone#: _____ Appointments Financial Dental Treatment Insurance

Other (explain): _____

Name: _____ Relationship: _____

Phone#: _____ Appointments Financial Dental Treatment Insurance

Other (explain): _____

DO NOT RELEASE INFORMATION

I understand that my express consent is required any health care information. With my signature below, I acknowledge and understand that this information will be kept in my medical record and the above parameters will remain in effect until revoked by me in writing. It is my responsibility to notify my healthcare provider(s) should I wish to change one or more contacts listed above.

Patient's name: _____ D.O.B.: _____

Patient or Representative Signature: _____

Date: _____



ACKNOWLEDEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have a copy of this office's Notice of
(Please Print Name}
Privacy Practices.

Printed Name of Responsible Party (If Patient is a Minor)

Signature

Date

FOR OFFICE USE ONLY

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

- Individual Refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION PLEASE REVIEW IT CAREFULLY THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also 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 April 14, 2003, 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 at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Person Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of you location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.