WECOME 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: ☐ 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 ALLTHAT APPY:

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

DRUGS/MEDICATIONS

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

☐ ASPIRIN (AA)	☐ IODINE (AD)	☐ NARCOTICS (NA)	☐ LATEX
☐ BARBITURATES (AB)	☐ KEFLEX (AK)	☐ PENICILLIN (AP)	☐ OTHER ALLERGIES (Please List)
☐ CODEINE (AC)	☐ LOCAL ANESTHETIC (LA)	☐ SULFA (AS)	_____
☐ ERYTHROMYCIN (AE)	☐ NITROUS OXIDE (NO)	☐ 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 bee 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 have 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 consultation 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 IN FORMATION

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.8.: _____

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:

D Individual Refused to sign

D Communication barriers prohibited obtaining the acknowledgement

D An emergency situation prevented us from obtaining acknowledgement

D Other (Please Specify)

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 HEALHT 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 a 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.