HARRIS
FAMILY DENTISTRY

PATIENT REGISTRATION

First Name: _____ Last Name: _____

Middle Initial: _____ Preferred Name: _____ Student Status: Full Time: ___ Part Time: ___

◯ Male ◯ Female Birthdate: _____/_____/_____ Soc Sec: _____

Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Widowed Pharmacy: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell: _____

Work Number: _____ Ext: _____ Position: _____

Whom may we thank for referring you to our office? Friend's name _____ ◯ Internet ◯ Drove by

◯ Facebook Other: _____

Previous Dentist: _____ Phone: _____

Patient is Responsible Party ◯ Yes ◯ No if not, :

Responsible Party Name: _____ Date of Birth: _____/_____/_____

Address if different than patient, Street: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell: _____ Work: _____

Employer: _____ Position: _____

Primary Insurance Information: Relationship to patient ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Name: _____ Insured birthdate: _____/_____/_____

Employer: _____ Phone: _____

Insurance Carrier: _____ Group Number: _____

Id # or Soc Sec: _____ Insurance Phone:_____

Secondary Insurance Information: Relationship to patient ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Name: _____ Insured birthdate: _____/_____/_____

Employer: _____ Phone: _____

Insurance Carrier: _____ Group Number: _____

Id # or Soc Sec: _____ Insurance Phone:_____

Thank you for choosing us as your dental provider!

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication you may be taking, could have an important interrelationship with the dentistry you will receive. Please answer the following questions.

Are you under a physicians 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, _____

Do you use tobacco? ◯ Yes ◯ No ◯ Cigarettes ◯ Smokeless Times per day? _____

Do you use controlled substances? ◯ Yes ◯ No if yes, _____

Current Medications: _____

_____

Are you taking blood thinners? ◯ Yes ◯ No Are you taking or ever taken Bisphosphonates? ◯ Yes ◯ No

Are you allergic to any of the following?

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

Other Allergies: _____

Women are you ◯ Pregnant/trying to get pregnant ◯ Nursing ◯ Taking oral contraceptives?

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

AIDS/HIV Positive	◯ Yes	◯ No	Cortisone Medicine	◯ Yes	◯ No	Hepatitis A	◯ Yes	◯ No	Reflux	◯ Yes	◯ No
Alzheimer's Disease	◯ Yes	◯ No	Diabetes	◯ Yes	◯ No	Hepatitis B or C	◯ Yes	◯ No	Renal Dialysis	◯ Yes	◯ No
Anaphylaxis	◯ Yes	◯ No	Drug Addiction	◯ Yes	◯ No	Herpes	◯ Yes	◯ No	Shingles	◯ Yes	◯ No
Anemia	◯ Yes	◯ No	Dry Mouth	◯ Yes	◯ No	High Blood Pressure	◯ Yes	◯ No	Sickle Cell Disease	◯ Yes	◯ No
Angina	◯ Yes	◯ No	Emphysema	◯ Yes	◯ No	High Cholesterol	◯ Yes	◯ No	Sinus Problems	◯ Yes	◯ No
Arthritis/Gout	◯ Yes	◯ No	Epilepsy or Seizures	◯ Yes	◯ No	Hives/Rash	◯ Yes	◯ No	Spina Bifida	◯ Yes	◯ No
Artificial Heart Valve	◯ Yes	◯ No	Excessive Bleeding	◯ Yes	◯ No	Hypoglycemia	◯ Yes	◯ No	Stomach Disease	◯ Yes	◯ No
Artificial Joint	◯ Yes	◯ No	Excessive Thirst	◯ Yes	◯ No	Irregular Heartbeat	◯ Yes	◯ No	Stroke	◯ Yes	◯ No
Asthma	◯ Yes	◯ No	Fainting /Dizziness	◯ Yes	◯ No	Kidney Problems	◯ Yes	◯ No	Swelling of Limbs	◯ Yes	◯ No
Blood Disease	◯ Yes	◯ No	Frequent Cough	◯ Yes	◯ No	Leukemia	◯ Yes	◯ No	Thyroid Disease	◯ Yes	◯ No
Blood Transfusion	◯ Yes	◯ No	Frequent Diarrhea	◯ Yes	◯ No	Liver Disease	◯ Yes	◯ No	Tonsillitis	◯ Yes	◯ No
Breathing Problems	◯ Yes	◯ No	Frequent Headaches	◯ Yes	◯ No	Low Blood Pressure	◯ Yes	◯ No	Tuberculosis	◯ Yes	◯ No
Bruise Easily	◯ Yes	◯ No	Glaucoma	◯ Yes	◯ No	Lung Disease	◯ Yes	◯ No	Tumors/Growths	◯ Yes	◯ No
Cancer	◯ Yes	◯ No	Hay Fever	◯ Yes	◯ No	Mitral Valve Prolapse	◯ Yes	◯ No	Ulcers of Mouth	◯ Yes	◯ No
Chemotherapy	◯ Yes	◯ No	Heart Attack/Failure	◯ Yes	◯ No	Osteoporosis	◯ Yes	◯ No	Ulcers of Stomach	◯ Yes	◯ No
Chest Pains	◯ Yes	◯ No	Heart Murmur	◯ Yes	◯ No	Pain in Jaw Joints	◯ Yes	◯ No			
Cold Sore/Fever Blisters	◯ Yes	◯ No	Hemophilia	◯ Yes	◯ No	Psychiatric Care	◯ Yes	◯ No			
Congenital Heart Disorder	◯ Yes	◯ No	Heart Pacemaker	◯ Yes	◯ No	Radiation Treatments	◯ Yes	◯ No			
Convulsions	◯ Yes	◯ No	Heart Disease	◯ Yes	◯ No	Recent Weight Loss	◯ Yes	◯ No			

If you said yes to heart attack, cancer or stroke, please list details and dates:_____

_____

To the best of my knowledge, the above questions have been accurately answered. I understand 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.

X _____ Date: _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Harris Family Dentistry

Telephone: 706-216-7777 Fax: 706-216-6478

E-mail: info@harrisfamilydentistry.com

Address: 212 Prominence Court Dawsonville, GA 30534

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

Consent to Obtain Medical Records:

I hereby authorize Harris Family Dentistry to obtain medical records from any other physician or medical facility necessary in the course of my treatment.

Consent to Release Medical Information and/or Records to a Spouse, Family Member or Significant Other:

I hereby authorize Harris Family Dentistry to release and information contained in my medical record to the persons listed:

1)_____2)_____ 3)_____

**If you do not authorize information to be released to anyone please circle this statement.*

I do not authorize any information to be released to anyone other than myself.

I hereby authorize messages to be left on a voice mail system or answering machine numbers listed on the patient information form.

Acknowledgement of Privacy Rights:

By signing below, I acknowledge that the notice of Privacy Practices and Individual Rights has been made available.

I acknowledge I have read the above, am giving my consent to the above and am acknowledging I have been informed of my rights to privacy.

Signature:_____ Date:_____

FINANCIAL AGREEMENT/CANCELLATION POLICY

Insurance: Please know and understand that your dental insurance is a contract between you and your dental insurance company. We file insurance as a courtesy to our patients. It is your responsibility to know and understand your dental insurance coverage in regards to maximums, frequencies and procedures covered and non-covered services.

I hereby authorize any insurance benefits to be paid directly to Harris Family Dentistry P.C. and recognize my responsibility to pay for all non-covered services and my estimated patient portion at the time of service. I also authorize the release of any information necessary to process an insurance claim.

I acknowledge that all non-current balances on accounts over sixty days will be charged a service charge of 1.5% per month on the unpaid balance. Any additional costs incurred in collecting on this account will be added to your balance due and will be your responsibility. Effective January 1, 2012, a statement re-billing fee of $15.00 per month will be added to all accounts with patient balances over 60 days. This is in accordance with our financial policy.

I further understand that treatment recommendation may change due to severity or time elapsed between diagnosis and treatment. Permission is hereby given for any medical/surgical procedures, x-rays, drug or laboratory test, medication, or exam as may be deemed necessary by the dentist. I understand I have the right to see a dentist, if I choose, and have the right to see the dentist prior to any prescription drug or device order being carried out by a dental assistant.

I, the undersigned (patient and legally responsible party) authorize treatment to be rendered and assume financial responsibility. Charges for all minors are the reasonability of the parent, guardian, or individual presenting the child for treatment. In the case of an unemancipated minor, the consent below is being given on his or her behalf.

FORMS OF PAYMENT:

Cash Check Visa/MasterCard/American Express

CareCredit – *offers a line of credit with no interest for promotional periods if applicant is approved. Please ask receptionist for brochure explaining the CareCredit options. To apply call 800-365-8295 or www.carecredit.com and click on "Apply".*

BROKEN AND LATE NOTICE CANCELLATION POLICY

Our office offers multiple courtesy reminders: appointment cards, phone calls, postcards through the mail, reminder email and texts to your cell number. If you are not receiving these electronic reminders and would like to do so, please contact our office to set up your contact information. We call to confirm as a courtesy, but it is the responsibility of the patient to respond to the confirmation calls/texts/emails and present for their appointment.

A broken or late cancellation affects other patients who are awaiting an appointment for needed treatment. Should you expect a schedule change please allow at minimum, a 48 business hour notification to reschedule your appointment. Without proper notice we are unable to offer the time to other patients who may be needing immediate care and are forced to charge a cancelled appointment fee of $50.00 to your account. Your cooperation with this matter is appreciated.

I have read the above Financial Agreement/Cancellation Policy and have asked any questions regarding the policy. By signing below, I understand and agree with the terms of this policy.

Signature of patient or responsible party Date

Office hours: Mon, Tue, Thu 8 am – 5 pm Wed & Fri 8 am – 4 pm

HARRIS
FAMILY DENTISTRY

212 Prominence Court

Dawsonville, GA 30534

We invite you to participate in our online system. Features include:

- · Request Appointments Online
- · Confirm Appointments via Email
- · Receive Text Message Appointment Reminders
- · Submit Patient Satisfaction Surveys

Please Verify Your Contact Information

Name : _____

Cell Number: _____ Receive Text YES NO

Email: _____ Receive Email YES NO

We use this information to provide you with excellent treatment. Our affiliates do not sell, share or rent our users' personally identifiable information unless required by law, do not send any e-mail or other communications without user permission, and do not send spam.

I agree to allow Demandforce to use this information in providing my services.

_____ _____

Signature Date