PATIENT REGISTRATION

ID: _____ Chart ID: _____

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: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

☐ 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: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Gender: ☐ Male ☐ Female ☐ Unknown Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: _____ Age: _____ Soc Sec: _____ Drivers Lic: _____

E-mail: _____ ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg: _____

Section 3

Referred By: _____

Emegency Contact: _____

Emergency # _____

Primary Dr. _____

Primary Dr. # _____

Ins Effective Date: _____

Primary Insurance Information Dental only

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

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. 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 Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

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

Rem. Benefits: _____ Rem. Deduct: _____

Blaire E. Warren , DDS, PLLC

Warren General Dentistry (Corrected! Use this one)

Patient Name: Birth Date: Date Created:

Please complete all sections, use "None" or "NA" where applicable.

Patient Allergies

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Sulfa Drugs
☐ Metal	☐ Latex	☐ Acrylic	☐ Local Anesthesia
☐ Hydrocodone			

Other? ☐ If yes

Are you currently taking any medications? (please list) ◯ Yes ◯ No If yes

Are you currently under the care of a physician? If so, who and why? ◯ Yes ◯ No If yes

Please list any hospitalizations and previous surgeries. ◯ Yes ◯ No If yes

Are you taking or have your ever taken a Bisphosphonate drug to strengthen bones? (Ex: Fosamax, Boniva, Redast) ◯ Yes ◯ No If yes

Are you taking any of the following? (Please circle) Blood Thinners, Insulin, Nitroglycerin, or Recreational Drugs? ◯ Yes ◯ No If yes

Do you have TMJ problems: popping, clicking, pain, or locking of jaw joints? ◯ Yes ◯ No If yes

Have you had a bone or joint replacement? If yes, when and what bone or joint? ◯ Yes ◯ No If yes

Have you traveled outside of the country in the last 30 days or been exposed to someone who has? ◯ Yes ◯ No If yes

Have you ever had or do you have: (Circle YES or NO for each)

Fainting Spells	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Fever Blisters	◯ Yes ◯ No
Seizures or Epilepsy	◯ Yes ◯ No	Chest Pain or Angina	◯ Yes ◯ No	Mental Health Disorder	◯ Yes ◯ No
Prolonged Bleeding	◯ Yes ◯ No	Heart Attack	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Organ Transplant	◯ Yes ◯ No	Heart Disease	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No
Recent Hoarseness	◯ Yes ◯ No	Heart Valve Problem	◯ Yes ◯ No	Hepatitis/Liver Disease	◯ Yes ◯ No
Difficulty Swallowing	◯ Yes ◯ No	Heart Valve Replacement	◯ Yes ◯ No	Tuberculosis (TB)	◯ Yes ◯ No
Shortness of Breath	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Stomach Ulcers	◯ Yes ◯ No
Morning Cough	◯ Yes ◯ No	Atrial Fibrillation	◯ Yes ◯ No	Cancer	◯ Yes ◯ No
Sinus Trouble	◯ Yes ◯ No	Congestive Heart Failure	◯ Yes ◯ No	Radiation Treatment	◯ Yes ◯ No
Asthma or Lung Disease	◯ Yes ◯ No	Thyroid Problems	◯ Yes ◯ No	Reaction to Anesthesia	◯ Yes ◯ No
Anemia/Leukemia	◯ Yes ◯ No	HIV/AIDS	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Blood Disorders	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Tobacco Products	◯ Yes ◯ No
Kidney Problems	◯ Yes ◯ No				

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

FEMALES:

Are you pregnant or possibly pregnant? If yes, how many weeks? ◯ Yes ◯ No If yes

The above information is complete and accurate to the best of my knowledge. 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.

Signature of Patient, Parent or Guardian

X Date:

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Communications between Patients and their Families, Friends, or Caregivers

This form allows Blaire E. Warren, DDS, PLLC (Name of Practice) to communicate information about your care (e.g., appointments, labs, medication, treatment plans, billing information) to you and those you list on this form. Signing this form is optional, is not required to receive treatment, and does not expire until you end it in writing.

Patient Name: _____ (Last) _____ (First) _____ (Middle Initial)

Date of Birth: _____ mm/dd/yyyy **Main Contact Number:** (___) _____ ☐ Home ☐ Cell* ☐ Work

Mailing Address: _____ (Street)

_____ (City) _____ (State) _____ (Zip)

COMMUNICATING WITH YOU

PHONE

DETAILED MESSAGES PERMITTED

☐ Main Contact Number Above ☐ text (SMS)* ☐ voicemail/answering machine ☐ None

☐ Other: (___) _____ ☐ Home ☐ Cell* ☐ Work ☐ text (SMS)* ☐ voicemail/answering machine ☐ None

EMAIL*

☐ _____

☐ All information from this practice

☐ Appointment information only (request/confirm/cancel)

☐ Data breach notifications

☐ Billing/insurance information

COMMUNICATING WITH YOUR FAMILY, FRIENDS, OR CAREGIVERS

☐ This practice may communicate to the family members, friends, or caregivers listed below.

Spouse/Partner: _____ First and Last Name

Phone: (___) _____

Email:* _____

Other: _____ First and Last Name

Phone: (___) _____

Email:* _____

Relationship: _____

Check the box next to each type of information this practice may share.

☐ All information ☐ Prescriptions ☐ Appointments (request/confirm/cancel) ☐ Billing/Insurance

☐ Other: _____

Do not include:

☐ Mental health records ☐ Communicable diseases (e.g., HIV/AIDS) ☐ Alcohol/drug abuse treatment

* I understand that emails and texts are not always secure ways to communicate and could be intercepted and read by a third party. I am willing to accept this risk.
This practice is not responsible for the privacy or security of your health information once it is sent to you, or the recipient(s) listed above.

YOUR PHOTOS & MULTIMEDIA

	Photos/Images may be used/posted:
☐ Photo received from you or personal representative	☐ In office
☐ Photo taken by staff (e.g., pre/post procedure)	☐ On office's website Smile only
☐ Other: Text to our office	☐ Other: Email to our office

PATIENT RIGHTS & SIGNATURE

- You can end this authorization at any time in writing. See our Notice of Privacy Practices for exceptions. A termination will not apply to any releases of information that happen before we receive a written termination from you.
- The recipient of the information could use or release it in a way that federal or state laws do not protect. This practice is not responsible for the privacy or security of your health information after it is sent to those listed on this authorization.
- You can review or copy the information that will be used or released as described in this authorization.
- You do not have to sign this authorization to receive treatment from this practice.
- You understand that the information that will be used or released might include a communicable disease diagnosis such as HIV or a diagnosis related to mental health or substance abuse unless you exclude it above.
- All changes or updates to this form must be made in writing and signed by you (patient) or your personal representative. Minor edits (e.g., new phone number) can be made on this form, initialed, and dated instead of requiring a new form.

_____ _____

Patient/Personal Representative Signature **Date:** mm/dd/yyyy

Printed name and description of Personal Representative's authority (e.g., healthcare power of attorney)
(Attach documentation to support the personal representative's authority if not already on file with the practice)

_____

FOR OFFICE USE & REFERENCE ONLY

☐ This authorization has been terminated: _____ mm/dd/yyyy

The termination must be in writing and filed with the original authorization.

Date original signed authorization received: _____ mm/dd/yyyy

☐ Copy of original authorization provided to patient/personal representative (check if yes)

Notes: _____

_____

_____

It is recommended that the practice review this form with the patient or their personal representative periodically for changes (e.g., annually with insurance verification).

Warren Dentistry
Blaire E. Warren, DDS, PLLC
142 Doctors Drive
Boone, NC 28607
828-264-2762

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

Patients who carry dental insurance understand all dental services furnished are charged directly to the patient and he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms. However, this office cannot render services on the assumption our charges will be paid by an insurance company.

I understand the **fee estimate** listed for this dental care can only be extended for a period of **six months** from the date of the patient examination.

Fees for services are due at the time treatment is rendered. Payment may be made in cash, check, or by credit card. We also offer third party financing.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or guardian_____

Date:_____**Relationship to Patient**_____

Signature of guarantor of payment/responsible party_____

Date:_____**Relationship to Patient**_____

Warren Dentistry
Blaire E. Warren, DDS, PLLC
No Show/Late Arrival Policy

Thank you for trusting Warren General Dentistry with your dental care. When you schedule an appointment with our practice we set aside enough time to provide you with the highest quality dental care. Should you need to cancel or reschedule an appointment, **please contact our office as soon as possible and no later than 24 hours prior to your scheduled appointment.** This will allow us to schedule other patients. No shows disrupt the practice and an unfilled appointment is a lost chance to help another patient.

Please see our **No Show Policy** below, effective **September 1, 2018:**

- Any established patient who fails to show for their **first** scheduled appointment will be considered a **No Show** and will be mailed a reminder notice.
- Any established patient who fails to show for their **second** scheduled appointment will be charged **$50.00.**
- The fee is charged to the **patient, not the insurance company,** and is due at the time of the patient's next office visit.
- As a **courtesy**, we make reminder calls for appointments. Reminder post cards are mailed two weeks prior to your scheduled time. If you do not receive a reminder call or post card the above policy will remain in effect.

We understand there may be times when an unforeseen emergency occurs, and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances, please contact our office during regular business hours. Monday through Thursday.

Late arrival: When we reserve time for you, we require all that time to provide you with the highest quality care possible. When you are **late** it decreases our ability to accomplish this. If you arrive **more than 15 minutes late, your appointment may be rescheduled** in order to meet the needs of those who are on time for their pre-reserved visit. If this happens it will be considered a **missed appointment.**

I have read and understand the Warren Dentistry Appointment Cancellation/No Show Policy and agree to its terms.

_____	_____
Signature of Patient, Parent/Legal Guardian	Relationship to Patient
_____	_____
Printed Name	Date

Release of Records

Date:_____

I hereby authorize the office of _____
To release my dental records. The records will be transferred to:

Blaire E. Warren, DDS, PLLC
142 Doctors Drive
Boone, NC 28607

warren.dentistry.boone@gmail.com

Patient Name:_____
(please print)

Patient or Guardian Signature:_____

Date:_____

Type of records sent:_____

_____

The document(s) accompanying this transmission contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation and is required to destroy the information after its stated need has been fulfilled. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.