DREXEL HILL DENTAL P.C

PATIENT REGISTRATION FORM

NAME_____SS#_____

ADDRESS_____CITY, STATE,ZIP_____

BIRTHDATE_____HOME PHONE_____

CELL PHONE_____WORK PHONE_____

E-MAIL _____

CHECK <u>ONE</u> FOR APPOINMENT CONFIRMATION PREFERENCE:

□ EMAIL □ HOME PHONE □ CELL PHONE

EMERGENCY CONTACT_____PHONE _____

SPOUSE'S NAME_____SPOUSE'S SS#_____

SPOUSE'S BIRTHDATE_____SPOUSE'S CELL PHONE_____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

I understand that I am financially responsible for all services rendered by the practice. These services must be paid for at the time of the treatment. If I have any form of dental insurance, I must make the required co-payments at the time of treatment, and I am responsible for any services my insurance company rejects for payment. If I am not present to sign my insurance forms at the time the form is completed, my Dental office is authorized to sign and assist with any and all insurance forms pertaining to services rendered.

I understand that a parent or legal guardian must be present at every dental appointment for all children under the age of 18. I hereby authorize the Dental practice to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care.

Appointments that are cancelled or missed without 24 hours notice may be subject to a charge.

PATIENT/GUARDIAN SIGNATURE_____
DATE_____

MEDICAL HISTORY FORM

PHYSICIAN'S NAME_____PHONE#_____

MEDICATIONS FOR WHAT REASON

Are you presently under the care of a Doctor? _____
Have there been any changes in your health in the past year? Please describe_____
_____
Do you take antibiotic medications before dental treatment?_____
WOMEN: ARE YOU OR DO YOU THINK YOU MAY BE PREGNANT?_____

ARE YOU ALLERGIC TO OR HAVE YOU BEEN TOLD NOT TO TAKE: PLEASE CIRCLE.
Penicillin Sulfa Codeine Aspirin Novocain Other_____

If you have been treated for any of the below issues please circle.

Heart Murmur
Rheumatic Fever
Mitral Valve Replacement
Artificial Heart Valve
Heart Surgery (bypass)
Angina
Heart Attack
High/Low Blood Pressure
Stroke
Pacemaker
Radiation Therapy
Hip/Knee Replacement

Diabetes
Liver Disease (Hepatitis)
Hemophilia (Bleeding)
Anemia
Tuberculosis (TB)
Respiratory Diseases
Asthma
Mouth Sores
Convulsions/Epilepsy
Stomach Ulcers
HIV Positive (AIDS)
Birth Control Pills

DO YOU HAVE ANY OTHER MEDICAL CONDITIONS?_____

TO THE BEST OF MY KNOWLEDGE I HAVE ANSWERED THESE QUESTIONS ACCURATELY.

PATIENT SIGNATURE_____DATE_____

DENTIST SIGNATURE_____DATE_____

DREXEL HILL DENTAL P.C.

Acknowledgement of Receipt of Notice of the Privacy Act

You may refuse to sign this Acknowledgement

I _____have received a copy of this office's Notice of Privacy Practices.

Patient signature_____

Patient Name please print_____

Date_____

For Official Use Only

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

Individual refused to sign

Communication barriers prohibited the obtaining acknowledgement

An emergency situation prevented us from obtaining acknowledgement

Other_____

_____

Authorization Form

DREXEL HILL DENTAL P.C.

Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize **DREXEL HILL DENTAL P.C.** to use and/or disclose certain protected health information (PHI) about me to _____.

This authorization permits **DREXEL HILL DENTAL P.C.** to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

The information will be used or disclosed for the following purpose: "at the request of the individual."

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information.

I do not have to sign this authorization in order to receive treatment from **DREXEL HILL DENTAL P.C.**. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at:

DREXEL HILL DENTAL P.C.
1021 Pontiac Road
Drexel Hill, PA 19026

Signed by: _____ _____

Signature of Patient or Legal Guardian — Relationship to Patient

_____ _____

Print Patient's Name — Date

Patient/guardian must be provided with a signed copy of this authorization form.