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:

Sex: ☐ Male ☐ Female 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

Previous Dentist

Emergency Contact

Emergency Contact #

Primary 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:

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:

Medical History

So that we may provide you with the best possible care, it is important that you tell all dental personnel involved in your treatment about the general state of your health. Please complete this medical history form. This information is, of course, confidential.

Patient First Name: _____ Patient Last Name: _____

Date of Birth: _____ Home Phone: _____ Today's Date: _____

If you are completing this form for another person, what is your relationship to that person?

Your Name: _____ Relationship: _____

MEDICAL HISTORY

Physician's Name: _____

Address: _____

Are you now under the care of a physician? ○ Yes ○ No

If yes, for what reason? _____

Are you presently taking any medications/drugs/pills? ○ Yes ○ No

Have you or anyone in your family had an adverse reaction to local anestheisa, IV sedation, or general anesthesia? ○ Yes ○ No

Is there anything you would like to discuss privately with the Dentist? ○ Yes ○ No

MEDICATIONS

List prescriptions (including birth control pills), vitamins, herbal supplements, natural products, over-the-counter drugs taken routinely and controlled substances. Include dosages if available.

ALLERGIES / SENSITIVITIES

Are you allergic / sensitive (or ever had an adverse reaction) to: *Check all that apply or check none*

☐ Penicillin ☐ Codeine ☐ Local Anesthetic ☐ Metals ☐ LATEX ☐ **NONE**

☐ Aspirin ☐ Other Antibiotics ☐ Other Medications or Substances: _____

Describe Reaction: _____

BISPHOSPHONATES

Have you ever or are you currently taking or scheduled to begin taking any of the medications, alendronate (Fosamax®), risedronate (Actonel®) or ibrandronate (Boniva®) for osteoporosis or Paget's disease?

○ Yes ○ No

Since 2001, were you treated or are you presently scheduled to begin treatment with intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?

○ Yes ○ No Date Treatment Began: _____

-- For questions requiring longer responses, please use "Comments" section on page 3 of this form. --

Have you ever used or currently use tobacco products? ○ Yes ○ No How long ago did you quit? _____

☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Chew How much? _____ How often? _____

Do you use marijuana? ○ Yes ○ No How much? _____ How often? _____

Do you drink alcoholic beverages? ○ Yes ○ No How much? _____ How often? _____

Do you vape or use e-cigarettes? ○ Yes ○ No

WOMEN: Are you pregnant or suspect that you may be? ○ Yes ○ No **Are you nursing?** ○ Yes ○ No

Do you have, or have you ever had any of the following: (YES OR NO)

	YES	NO		YES	NO
1. Artificial (prosthetic heart valve)	○	○	32. Blood Disorders	○	○
2. Previous infective endocarditis	○	○	33. Anemia	○	○
3. Damaged valves in transplanted heart	○	○	34. Leukemia	○	○
4. Congenital heart disease (CHD)			35. Prolonged Bleeding	○	○
Unrepaired, cyanotic CHD	○	○	36. Hemophilia	○	○
Repaired (completely) in last 6 months	○	○	37. Sickle Cell Disease	○	○
Repaired CHD with residual defects	○	○	38. Cancer	○	○
5. Heart Disease/Surgery	○	○	39. Tumors	○	○
6. Heart murmur	○	○	40. Chemotherapy	○	○
7. Heart pacemaker	○	○	41. Radiation Therapy	○	○
8. Rheumatic fever/heart disease	○	○	42. Neurological Disorders	○	○
9. Mitral valve prolapse	○	○	43. Epilepsy	○	○
10. High/low blood pressure	○	○	44. Stroke	○	○
11. Learning Disability	○	○	45. Arthritis / Rheumatism	○	○
12. Mental Health Disorder	○	○	46. Autoimmune Disease	○	○
13. Anorexia	○	○	47. Artificial Joint / Prosthesis	○	○
14. Bulimia	○	○	48. Liver Disease	○	○
15. Lung disease/COPD	○	○	49. Hepatitis (select one)	○	○
16. Tuberculosis	○	○	Type: ○A ○B ○C ○Other ○None		
17. Asthma	○	○	50. Ulcers	○	○
18. Shortness of Breath	○	○	51. Gastrointestinal Disease	○	○
19. Respiratory Ailments	○	○	52. GERD (gastric reflux)	○	○
20. Emphysema	○	○	53. Deaf or Hard of Hearing	○	○
21. Sinus Trouble	○	○	54. Glaucoma	○	○
22. Diabetes Type I or Type II	○	○	55. Cortisone Medication	○	○
23. Thyroid Problems	○	○	56. Fainting Spells	○	○
24. Persistent swollen glands	○	○	57. Organ Transplant	○	○
25. Kidney Problems	○	○	58. Removal of Spleen	○	○
26. Venereal Disease	○	○	59. Osteoporosis	○	○
27. HIV Positive/AIDS/ARC	○	○	60. Sleep Disorder	○	○
28. Alcohol Addiction	○	○	61. Elevated Cholesterol	○	○
29. Drug Dependency	○	○	62. Anxiety	○	○
30. Chemical Dependency	○	○	63. Depression	○	○
31. Dementia	○	○	64. Alzheimer's	○	○

Have you had any other serious illness, hospitalization or accident? ○ Yes ○ No

If yes, please explain: _____

-- For questions requiring longer responses, please use "Comments" section on page 3 of this form. --

COMMENTS

I understand the information entered on this form is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.

When completing a printed form, please sign below

Patient _____ Date _____

Patient or Patient Guardian

Doctor _____ Date _____

Doctor or Provider of Care

Dental History

Patient First Name: _____ Patient Last Name: _____

Home Phone: _____ Reason for your visit? _____

Previous dentist's name: _____

Previous dentist's address: _____

How often do you...

brush your teeth? _____

floss your teeth? _____

have dental exams? _____

What was the date of your last...

visit? _____

hygiene visit? _____

X-Ray? _____

What other aids do you use (electric toothbrush, toothpick, etc.)? _____

Do you have any dental problems? ○ Yes ○ No

If yes, explain: _____

Personal History	**YES**	**NO**
1. Have you ever had orthodontic treatment?	○	○
2. Have you ever had oral surgery?	○	○
3. Have you ever had any teeth removed?	○	○
If so, have they been replaced? ○ Yes ○ No		
4. Have you ever had a fixed bridge?	○	○
5. Have you ever had removable partial?	○	○
6. Have you ever had complete denture?	○	○
7. Have you ever had implants?	○	○
If so, are you happy with the replacements? ○ Yes ○ No		
8. Have you ever had periodontal treatment?	○	○
9. Have you ever had gum surgery?	○	○
If so, when? _____		
by whom? _____		
10. Have you ever had your teeth ground or bite adjusted?	○	○
11. Have you ever had a serious injury to the mouth or head?	○	○
If so, please describe (include cause): _____		
12. Do you feel anxiety about having dental treatment?	○	○
How did you overcome your anxiety? _____		
13. Have you ever had an upsetting dental experience?	○	○
If yes, please describe: _____		

Smile Characteristics	YES	NO
1. Do you like the appearance of your teeth and smile?	○	○
2. Do you like the color of your teeth?	○	○
3. Would you like your teeth straightened?	○	○
4. What would you like to change most in the appearance of your teeth?		

Tooth Structure		
1. Are any of your teeth sensitive to hot or cold liquids/foods?	○	○
2. Are any of your teeth sensitive to sweet or sour liquids/foods?	○	○
3. Are any of your teeth sensitive to biting or pressure?	○	○
4. Have you noticed any loose teeth or change in your bite?	○	○
5. Do you get food caught between your teeth?	○	○

Gum and Bone		
1. Have you ever noticed any mouth odors or bad taste?	○	○
2. Do you frequently get cold sores, blisters, or any lesions?	○	○
3. Do your gums bleed or hurt?	○	○
4. Have your parents experienced gum disease or tooth loss?	○	○

Bite and Jaw Joint		
1. Do you clench or grind teeth (awake or asleep)?	○	○
2. Do you have tired jaws (especially in the morning)?	○	○
3. Do you bite your lips or cheeks regularly?	○	○
4. Do you hold foreign objects with your teeth (pencils, pens, nails, fingernails, pipe)?	○	○
5. Do you mouth breathe while asleep or awake?	○	○
6. Do you snore?	○	○
7. Have you ever experienced clicking or popping of the jaw?	○	○
8. Have you ever experienced pain (joint, ear or side of face)?	○	○
9. Have you ever experienced difficulty opening or closing the mouth?	○	○
10. Have you ever experienced frequent headaches, neck aches, or shoulder aches?	○	○
11. Have you ever experienced any pain or soreness in the muscles of your face or around the ears?	○	○

Is there anything else about having dental treatment that you would like to let us know?

I consent to the doctor's exam and necessary diagnostics for treatment including x-rays.

When completing a printed form, please sign below

Patient _____ Date _____

Patient or Patient Guardian

Doctor comments:

When completing a printed form, please sign below

Doctor _____ Date _____

Doctor or Provider of Care

HIPPA Privacy Acknowledgement of Receipt of Notice of Privacy Practice

Patient

DOB PT No.

I, **X**_____ [Please print full legal name here] (the "Patient" or "Patient's legal representative"), have been presented with the Notice of Privacy Policy of Takii Family Dentistry, and have been offered a copy of such to keep for my records.

PLEASE INITIAL THE FOLLOWING:

X_____ I hereby acknowledge that I have read the Policy and understand its terms and conditions.

X_____ I hereby refuse to acknowledge receipt of the Policy and refuse to read or acknowledge any of the terms and conditions of the Policy. I understand that even though I may refuse to sign this acknowledgement, Provider may still provide treatment to me.

X_____ **X**_____

SIGNATURE OF PATIENT DATE

FOR OFFICE USE ONLY

I,_____ [Please print full legal name here], acting as _____

[Please print relationship to or official position with Provider] for Provider attempted to obtain the written acknowledgment of receipt of the Policy of Provider on_____ [Please insert date attempt was made], but acknowledgement could not be obtained because:

PLEASE INITAIL THE FOLLOWING:

_____ Patient or Patient's legal representative refused to sign.

_____ Patient or Patient's legal representative could not be communicated with sufficient to obtain acknowledgement.

_____ Emergency Circumstances prevented securing acknowledgement.

_____ Other (Please specify)

_____

_____

_____ _____

SIGNATURE OF PROVIDER REPRESENTATIVE **DATE**

Dental Treatment General Consent Form

Patient:

Date of Birth: **PT No.**

Please read and initial the items checked below. Please read and sign the section at the end of the form.

_____ **1. WORK TO BE DONE**

I understand that one or more of the following items may be recommended to be done: fillings, crowns, bridges, partials, dentures, implants, extractions, root canals, and/or cleanings.
I understand that I will be given a more detailed consent for these procedures discussing possible risks, benefits, and alternative options.

_____ **2. DRUGS AND MEDICATIONS**

I understand that any medications (including antibiotics and analgesics) can cause allergic reactions resulting in redness/swelling of tissues, hives, pain, itching, vomiting, difficulty breathing, anaphylactic shock (severe allergic reaction).
I understand that if any of these reactions were to occur, I should immediately stop taking the medication and contact my dental care provider. I have informed my dental providers of any known drug allergies and will keep them updated regarding any changes. Certain medications (including analgesics and anti-anxiety agents) may cause drowsiness and slowed reflexes and that it is advisable not to drive or operate hazardous equipment when using such medications.

_____ **3. USE OF LOCAL ANESTHETICS**

I understand that local anesthetics may be used for purpose of providing dental procedures in a comfortable manner, for diagnosing, or for treating facial pain. I authorize my doctor to administer anesthetics that may be deemed appropriate.
I understand that potential complications include, but are not limited to, pain, swelling, bruising, temporary limited opening, and local infection. I understand that in occasional cases the anesthesia may be prolonged and in very rare cases permanent.

_____ **4. CHOICE OF MATERIALS**

In any filling situation, there are various choices of materials (amalgam, composite resin, gold foil, porcelain/gold inlays or onlays). Your doctor will make the best treatment choice recommendation for your dental need.

_____ In any crown/bridge situation, there are various choices of materials (stainless steel, high noble metals, noble metals, porcelain fused to metal, all-porcelain). Your doctor will make the best treatment choice recommendation for your dental need.

_____ **5. CHANGES IN THE TREATMENT PLAN**

I understand that during treatment it may be necessary to change or add procedures because of conditions discovered during treatment that were not evident during examination. I authorize my doctor to use professional judgment to provide appropriate care.

_____ **6. RADIOGRAPHS**

I understand that radiographs (x-rays) may need to be taken in order to provide a thorough complete examination or to receive optimal levels of treatment. I authorize my doctor to use professional judgement to take any needed radiographs.

_____ **7. EXPOSURE**

In the event that any of my dental providers is exposed to my blood and other bodily fluids, I agree to have my blood drawn and tested for hepatitis B virus (HBV), hepatitis C virus (HCV), and the human immunodeficiency virus (HIV). I understand that this testing would be done in a confidential manner and that the results would be made available only to the person who was exposed. I understand that the costs of these procedures and tests would be assumed by my dental provider.

_____ **8. INTERNS / OBSERVERS**

On rare occasions, an intern or observer may be in the dental office to gain experience or to evaluate the standards of the practice. These opportunities are an integral part in development of staff. I understand that I may be asked permission to allow these individuals to observe or to help in my dental procedure. I understand that I have the right to refuse this request.

I understand that dentistry is not an exact science and that no specific results can be assured or guaranteed. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorize. I have had the opportunity to read the entire general consent form and to have all my questions answered by my doctor to my satisfaction. I consent to the proposed, recommended treatment.

Signature of Patient _____ Date _____

Signature of Parent/Guardian if patient is a minor _____ Date _____

Signature of Dentist _____ Date_____

Financial Policy

Patient

DOB **PT No.**

We are pleased that you have selected us as your dental care provider. For your knowledge, our Financial Policy is outlined below.

Promise to Pay. Amounts for dental care services provided to you or your family members may be charged to your Account unless you specifically instruct us otherwise. You promise to pay us all amounts owed on your Account (your "Balance") under the terms of this Financial Policy when billed. If you have insurance, the amount you owe for services may be estimated based on the amount anticipated to be paid by your insurance company. We will assist you with an insurance claim; however, insurance is a contract between the policyholder and insurance company. The anticipated amount to be paid by your insurance company may be charged to your account until we receive payment from your insurance company. However, I the event your insurance company is slow to payor disallows a claim, payment of your Account is your full responsibility. We may also charge your account fees set forth below for missed appointments, late payments, returned payments or collection costs. We will provide to you a statement (your "Statement") of your balance, which will be payable when you receive your Statement. We may indicate on your Statement that your Balance is "pending insurance" and thus not yet payable by you. If you have Insurance coverage, we may choose not to ed you a Statement until we know or receive the amount reimbursable by your insurance company.

Missed Appointment Fee. We may charge to your Account fees for a missed appointment or fees for an appointment cancelled without advance, notice of at least 24 hours.

Late Payment Fee. If we do not receive payment in full of your Balance within 30 days of the Statement, you will be assessed a Late Payment Fee of 2.00% of your unpaid Balance each month. We may not allow further appointments, unless in exceptional circumstances, until we receive full payment of your balance.

Returned Payment Fee. If any check or other payment that you have made on your Account is returned unpaid, you will be charged a Return Payment Fee, which is currently $30.00 and may be adjusted.

Collection Costs. If we do not receive payment under the terms of the Financial Policy and we refer your Account to a collection agency or an attorney for collection, we may charge to our Account or otherwise collect from you our collection costs, including court costs and reasonable attorneys' fees to the extent not prohibited by applicable law.

No Waiver by Us. We may waive our right to charge a fee to your Account without waiving ay other right we have under this Financial Policy including our right to charge that same fee at any other time.

Credit Reports. We or a collection agency or attorney acting on our behalf, may report late payments, missed payments or other default on your account to credit reporting agencies. If you believe that we have information about you that is inaccurate or that we have reported or ay report to a credit reporting information about you that is inaccurate, please notify us of the specific information that you believe is inaccurate by writing to us at the address above.

As used in this Financial Policy, "we", "us", "our" and "Provider" mean the service provider named above. "Services" means any services provided by us. "You," "your" and "Account holder" mean the person responsible for paying for services, Payment for services is due when services are provided unless as noted otherwise above. By signing below, you are requesting that we establish an open account for you (your "Account") as an accommodation to you for the tracking and payment of amounts due, and you agree to the terms of this Financial Policy.

Yes, I agree to the above terms and conditions.

X _____ **X** _____ **X** _____

Account Holder's Signature *Print Name* *Date*

No, I am not interested in establishing an account and therefore understand that full payment for dental care services, subject to limitations imposed by my insurance company, if any, is due at the time of appointment.

X _____ **X** _____ **X** _____

Account Holder's Signature *Print Name* *Date*

Scheduling Policy

We at Takii Family Dentistry are here to take care of *you*, our patient. We try to schedule our patients well in advance of the due date for their next dental appointment. If it is not possible to schedule your appointment in advance, we will do everything we can to keep you on the doctor-recommended schedule.

When we book you for your appointment, your dental professional has a specific amount of time reserved for you. We care greatly about your oral health, and missing a dental appointment makes maintaining a healthy smile difficult. We strongly encourage all patients to keep their appointments unless prevented by an emergency or illness.

If you know in advance you will not be able to keep an appointment with your doctor or hygienist, please provide us with as much notice as possible so that we may offer that appointment time to another patient. If you must change your appointment, we require a minimum of 24 hours' notice to avoid a $25.00 cancellation fee. Extenuating circumstances and emergency situations are exempt from this fee. If you pay a fee for a missed appointment, it may be applied as credit towards a copay for future dental services, at the discretion of the practice.

The dental office is a setting for many different types of dental visits, including dental emergencies. In accommodating a patient with a dental emergency, it may interfere slightly with your appointment time. We greatly appreciate your understanding if this circumstances ever arises, and we assure you we will teat you or your family with the same level of service if you experience an emergency requiring a same-day remedy.

Signature: _____ Date: _____