PATIENT REGISTRATION

ID:	Chart ID:		
First Name:			Middle Initial:
Patient Is: Policy Ho			
First Name:		Last Name:	Middle Initial:
			Pager:
Home Phone:	Work Phone:	Ext:	Cellular:
Birth Date:			Drivers Lic:
O Responsible Party		O Primary Insurance Policy Hold	
Patient Information		C 1 finding modification of oney from	O Secondary insurance Policy Holder
Address:	W 644	Address 2:	
		State / Zip:	
Home Phone:	Work Phone:	Ext:	Cellular:
Sex:		arital Status: Married Sir	
() Ividio		Soc. Sec:	
			THE RESIDENCE OF THE PROPERTY
		I would like to rece	eive correspondences via e-mail.
Section 2	O	On., .	Section 3 Referred By:
Employment Status:	9	Retired	Previous Dentist:
Student Status: OF	ull Time Part Time		Emergency Contact:
Medicaid ID:	Pref. Dentist	•	Emergency Contact #:
Employer ID:	Pref. Pharma	acy:	
Primary Insurance Inform	mation	Pelationship	to Insured: Self Spouse Child Other
Name of Insured:			to insured. Self Spouse Critic Other
Insured Soc. Sec:		Insured Birth Date:	
Employer:		Ins. Company:	
Address:		Address	97
Address 2:		Address 2	
):
	.00 Rem. Deduct:		
	nformation		
		Relationship	to Insured: Self Spouse Child Other
	ACCUSANCE AND A PROCESSION OF THE PROCESSION OF		
11-50-00			
Address:			X
		Address 2	
Address 2:		Addless 2	
			D:

Drs. Chin Pharar Medical History

Patient Name:

Signature of Patient, Parent or Guardian:

X

Medical His Birth Date:

Heght: Weight: Weight: Are you used to Aphyciatris care now? If so for what reason or Yes No If yes Serve you even been hospitated of had a major oceration? Yes No If yes Serve you seve been hospitated of had a major oceration? Yes No If yes Serve you seve had a sethout head or next pury? Are you laking any medications, pils, or drugs? Are you laking any medications, pils, or drugs? Are you laking any medications, pils, or drugs? Are you to strong you take, Phen-file or Reduct? Yes No If yes Serve you strong the strains, formary, actional rank your was produced any of the following of the strains of the strong or you have you are take accounted abbettors or ? How much per day? For how long? Yes No If yes Serve you was to been or ? How withen and for how long? Yes No If yes Serve you was controlled abbettors or ? How withen and for how long? Yes No If yes Serve you was controlled abbettors or ? How withen and for how long? Yes No If yes Serve you was controlled abbettors or ? How withen and for how long? Yes No If yes Serve you was controlled abbettors or ? How withen and for how long? Yes No If yes Serve you was controlled abbettors or ? How withen and for how long? Yes No If yes Serve you was controlled abbettors or ? How withen and for how long? Again Serve you was produced abbettors or ? How withen and for how long? Again Serve you was produced abbettors or ? How withen and for how long? Harring? Prepared/Threety to get prognant? Are you diving to any of the following? Harring? Prepared/Threety to get prognant? If yes Serve you was prognant? Yes No If yes Serve you have you land, any of the following? Harring? Prepared/Threety to get prognant? Yes No If yes Serve you have you land, any of the following? Harring? Prepared/Threety to get prognant? Yes No If yes Serve you have you land, any of the following? Harring? Prepared/Threety to get you have you was for for the following? Harring? Prepared/Threety to get you have you land, any of the following? Harring? Prepared/Three	taking, could have an import	carre arrecers	Cicioni	ip mar are acreas	., ,		, , , , , , , , , , , , , , , , , , , ,		3 4			
Are you under a physician's care now? If so for what reason and for how long? Are you taking any medications, pils, or drugs? Are you taking any medications, pils, or drugs? Yes No If yes Do you take, or hove you taken, Phenefren or Red.xii? Yes No If yes Do you take, or hove you taken, Phenefren or Red.xii? Yes No If yes Do you take on the person or red.xii? Yes No If yes Do you take controlled substances not prescribed? Yes No If yes Do you use controlled substances not prescribed? Yes No If yes Do you use controlled substances not prescribed? Yes No If yes Do you use controlled substances not prescribed? Yes No If yes Do you use controlled substances not prescribed? Yes No If yes Do you use controlled substances not prescribed? Yes No If yes Do you use controlled substances not prescribed? Yes No If yes Do you use controlled substances not prescribed? Yes No If yes Do you use controlled substances not prescribed? Yes No If yes Do you use controlled substances not prescribed? Yes No If yes Do you way, or have you had, any of the following? Herpanari/Triving to get pregnant? Authorize to any of the following? His positive Yes No If yes Do you have, or have you had, any of the following? His positive Yes No If yes Do you have, or have you had, any of the following? His positive Yes No If	Height :											
tive you under a physiciant's care non? If so for what reason and fire how long? If yes and fire how long? Yes No If yes are you were been hopatabled or had a major operation? Yes No If yes are you were been hopatabled or had a major operation? Yes No If yes are you were been hopatabled or had a major operation? Yes No If yes are you been hopatabled or had a major operation? Yes No If yes are you had a serious head or neck rijury? Yes No If yes are you had a serious head or neck rijury? Yes No If yes are you had a serious head or neck rijury? Yes No If yes are you had a serious head or neck rijury? Yes No If yes are you had a serious head or neck rijury? Yes No If yes are you had a serious head or neck rijury? Yes No If yes are you had a serious head or neck rijury? Yes No If yes are you had a serious head or neck rijury? Yes No If yes are you had a serious head or neck rijury? Yes No If yes are you had a serious head or neck rijury? Yes No If yes are you had a serious head or neck rijury? Yes No If yes are you had a serious head or neck rijury? Yes No If yes are you had a serious head or neck rijury? Yes No If yes are you had a serious head or neck rijury? Yes No If yes are you had a serious head or neck rijury? Yes No If yes are you had a serious head or neck rijury? Yes No If yes are you had a serious head or neck rijury? Yes No If yes are you were ripury and you had a serious head or neck rijury? Yes No If yes are you were not get a serious ripury and you had a serious head or neck rijury? Yes No If yes are you were head or neck rijury? Yes No If yes are you were head or neck rijury? Yes No If yes are you were head or neck rijury? Yes No If yes are you were head new you had, any of the following? If yes are you were head new you had, any of the following? If yes are you were head new you had, any of the following? If yes are you were not yes no If yes No If yes No If yes If	Weight:											
and for flow loon of 2 we've you ever been hospitalized or had a major operation? We's No If Yes we'you see'r been hospitalized or had a major operation? We's No If Yes we'you see'n base seems head or neck injury? We's No If Yes No you taking any medications, pils, or drugs? We's No If Yes No you see the flow or you taken, Pien-fren or Reduc? We's No If Yes No you we've you on a special det? We's No If Yes No you use controlled substances not networked? We's No If Yes No you use controlled substances not networked? We's No If Yes No you wa've ? If so how often and for how long? Yes No If Yes No you wa've ? If so how often and for how long? Nursing? Taking oral controceptives? Takin												
sove you ever had a senious head or neck injury? If yes If y		care now	? If so fo	r what reason	(Yes	○ No	If yes					
Ne you taking any medications, pills, or drugs? Yes No If yes If yes	Have you ever been hospita	lized or h	nad a majo	or operation?	Yes	⊚ No	If yes					
Do you take, or have you taken, Phen-Pen or Reduck? Yes No If yes take you ser taken Fosanax, Bonkiva, Actorael or any other neckclastons containing besithosphonates or for Osteoperosis? Yes No If yes Yes No If y	Have you ever had a seriou	s head or	neck inju	ıry?	(Yes	⊜ No	If yes					
tave you ever taken Fosamax, Boniva, Actonel or any other electionize containing bisphosphoralises or for Osteoperose? Yes No If yes To you use tobacco or ? How much per day? For how long? Yes No If yes On you use controlled substances not prescribed? Yes No If yes On you use controlled substances not prescribed? Yes No If yes On you use controlled substances not prescribed? Yes No If yes On you use controlled substances not prescribed? Yes No If yes On you use controlled substances not prescribed? Yes No If yes On you was controlled substances not prescribed? Yes No If yes On you was controlled substances not prescribed? Yes No If yes On you was controlled substances not prescribed? Yes No If yes On you was controlled substances not prescribed? Yes No If yes On you was you have on fithe following? If yes On you was you have, or have you had, any of the following? If yes Other? If yes Other? If yes Other? If yes Others If yes Others If yes Others Others If yes Others Others If yes Others Others If yes Others Others Others If yes Others	Are you taking any medicati	ons, pills,	or drugs	?	Yes	⊚ No	If yes					
redications containing bisphosphonates or for Osteoperosis? **Vere you on a special diet?** **Vere you on a special diet?** **Vere you on a special diet?* **Vere you on If yes **Do you wase tobsocco or ? How much per day? For how long?* **Vere you on If yes **Do you wase p? If so how often and for how long?* **Pregnant/Trying to get pregnant?* **Pregnant/Trying t	o you take, or have you ta	ken, Phe	n-Fen or	Redux?	① Yes) No	If yes					NAME OF THE PARTY
Do you use tobacco or ? How much per day? For how long? Yes No If yes Do you use controlled substances not prescribed? Yes No If yes Do you Vape ? If so how often and for how long? Yes No If yes Jone 1					O Yes	⊕ No	If yes					
Do you use controlled substances not prescribed? Yes No If yes Do you Vape? If so how often and for how long? Yes No If yes Omen: Are you Pregnant/Trying to get pregnant? Nursing? Codeine Acrylic Sulfa Drugs Codeine Acrylic Sulfa Dru	Are you on a special diet?				@ Yes	⊚ No						
Do you Vape? If so how often and for how long? Yes No If yes Pregnant/Trying to get pregnant?	Do you use tobacco or ? Ho	w much p	per day? f	For how long?	(Yes	⊜ No	If yes					
Do you Vape? If so how often and for how long? Yes No If yes somen: Are you Pregnant/Trying to get pregnant?	Do you use controlled subst	ances no	t prescrib	ed?	① Yes	⊕ No	If ves					
omen: Are you Pregnant/Trying to get pregnant?	Do you Vape ? If so how oft	en and fo	or how lor	ng ?								
Pregnant/Trying to get pregnant? Aspirin Penicillin Codeine Acrylic Aspirin Penicillin Codeine Acrylic Metal Latex Sulfa Drugs Local Anesthetics Oyou have, or have you had, any of the following? HIV Positive Yes No Alzheimer's Disease Yes No Anaphylaxis Yes No Anaphylaxis Yes No Anaphylaxis Yes No Anaphylaxis Yes No Angina Yes No Emphysema Yes No Arthrita/Gout Yes No Emphysema Yes No Arthrita/Horu Yes No Arthrita/Horu Yes No Excessive Blieding Yes No Hive or Rash Yes No Scarlet Fever Yes No Arthrita/Sout Yes No Excessive Blieding Yes No Arthrita/Sout Yes No Excessive Splications Yes No Arthrita/Bola Dint Yes No Excessive Thirst Yes No Blood Disease Yes No Blood Disease Yes No Breathing Problems Yes No Breathing Problems Yes No Breathing Problems Yes No Bruse Easily Yes No Cancer Yes No Chenotherapy Yes No Chenotherapy Yes No Congenital Herart Bains Yes No Congenital Heart Disorder Yes No Congenital Herart Bains Yes N					J.C.	J.,,	,					
re you allergic to any of the following? Aspirin		orego ant	2		Nh regio =	2			Takina aust	contracentives?		
Aspirin Penicillin Codeine Acrylic Local Anesthetics Other?	regnand frying to get [o egnant:			rvur sir ig				l aking oral	conducepaves?		
Aspirin Penicillin Codeine Acrylic Local Anesthetics Other?	re you allergic to any of the	following	?									
Other?	Aspirin			Penicillin				Codeine		Acrylic		
you have, or have you had, any of the following? HIV Positive	Metal			Latex				Sulfa Drugs		Local Anesthetics		
you have, or have you had, any of the following? HIV Positive	Other?						75					
HIV Positive	Outer:						IT yes					
Alzheimer's Disease Yes No Diabetes Yes No Drug Addiction Yes No Hepatitis A Yes No Recent Weight Loss Yes No Anaphylaxis Yes No Drug Addiction Yes No Hepatitis A Yes No Renal Dialysis Yes No Anaphylaxis Yes No Drug Addiction Yes No Hepatitis Yes No Renal Dialysis Yes No Anaphylaxis Yes No Renal Dialysis Yes No Anaphylaxis Yes No Anaphylaxis Yes No Renal Dialysis Yes No R	o you have, or have you ha	d, any of	the follow	wing?								
Anaphylaxis	HIV Positive	Yes	○ No	Cortisone Medi	cine	Yes	No	Hemophilia	No Yes No	Radiation Treatments	Yes	01
Anemia Yes No Easily Winded Yes No Hipposama Yes No Hipposama Yes No Emphysema Yes No Emphysema Yes No Hipposama Yes No Emphysema Yes No Emphysema Yes No Hipposama Yes No Hipposama Yes No Emphysema Yes No Hipposama Yes No Emphysema Yes No Hipposama Yes No Heart Attack/Failure Yes No Osteoporosis Yes No Tumors or Growths Yes No Yellow Jaundice Yes No Heart Pacemaker Yes No Hea	Alzheimer's Disease	① Yes	○ No	Diabetes		Yes	○ No	Hepatitis A	Yes No	Recent Weight Loss	Yes	01
Angina	Anaphylaxis	① Yes	○ No	Drug Addiction		Yes	⊚ No	Hepatitis	Yes No	Renal Dialysis	Yes	01
Arthritis/Gout	Anemia	① Yes	○ No	Easily Winded		① Yes	⊚ No	Herpes	Yes No	Rheumatic Fever	Yes	01
Artificial Heart Valve	Angina	① Yes	◎ No	Emphysema		Yes	○ No	High Blood Pressure	Yes No	Rheumatism	Yes	01
Artificial Heart Valve	Arthritis/Gout			Epilepsy or Sei	zures			High Cholesterol		Scarlet Fever	(Yes	01
Artificial Joint	Artificial Heart Valve							Hives or Rash		Shingles		
Asthma												
Blood Disease												
Blood Transfusion											_	-
Breathing Problems		_										
Bruise Easily Yes No Genital Herpes Yes No Low Blood Pressure Yes No Swelling of Limbs Yes No Cancer Yes No Glaucoma Yes No Lung Disease Yes No Thyroid Disease Yes No Chemotherapy Yes No Hay Fever Yes No Mitral Valve Prolapse Yes No Thyroid Disease Yes No Cotes Pains Yes No Heart Attack/Failure Yes No Osteoporosis Yes No Thyroid Disease Yes No Unders Yes No Thyroid Disease Yes No Unders Yes No Thyroid Disease Yes No Unders Yes No Yes												
Cancer												
Chemotherapy												
Cold Sores/Fever Blisters Yes No Heart Attack/Failure Yes No Osteoporosis Yes No Tuberculosis Yes No Cold Sores/Fever Blisters Yes No Heart Murmur Yes No Pain in Jaw Joints Yes No Tumors or Growths Yes No Congenital Heart Disorder Yes No Heart Pacemaker Yes No Parathyroid Disease Yes No Ulcers Yes No Yellow Jaundice Yes No If yes No I												
Cold Sores/Fever Blisters												
Congenital Heart Disorder					ailure							
Convulsions												
Yellow Jaundice												
Have you ever had any serious illness not listed above?		Yes	○ No	Heart Trouble/	Disease	Yes	○ No	Psychiatric Care	Yes No	Venereal Disease	Yes	01
	Yellow Jaundice	Yes	⊚ No									
omments:	Have you ever had any seri	ous illnes	s not liste	ed above?	(Yes	○ No	If yes					
	omments:											
	1											

Date:

Agreement to Receive Electronic Communication

Our office utilizes email communication for your convenience which allows the following advantages:

- Appointment reminders
- Request or change appointments
- Answer patient questions
- Easy communication with our office

Patient Name:	Date of Birth:
I agree address below that the dental pracand email. Please provide your email addr	ctice may communicate with me electronically via text ess and cell phone number below.
Even though this office takes security ser that third parties might be able to read u	iously, I am aware that there is some level of risk nencrypted emails.
I am responsible for providing the dental p	practice any updates to my email address.
I can withdraw my consent to electronic c	ommunications by calling:
702-445-7075	
Email Address (PLEASE PRINT CLEARLY):@	Cell phone number:
Patient Signature:	
Date:	

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Acknowledgement of Receipt of HIPAA Policies and Procedures

This sample form illustrates how a dental practice might obtain acknowledgement of receipt from each workforce member that he or she has received a copy (in paper or electronic format) of the practice's privacy, security and breach notification policies and procedures.

Drs. Chin & Pharar Dentistry

I have received and reviewed a copy of our dental practice's privacy, security and breach notification policies and procedures.

I understand that I should ask our dental practice's Privacy Official if I have any questions about these policies and procedures.

Print Name:	 	
Signature:	 	
Date:		

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Dental History

Please IIII out to the best of your ability so that we can provide yo	ou with the necessary treatment.
Date of last dental visit: Purpose of visit:	
Previous Dentist:	
Last X-rays:	
Photograph Authorization	
On new patients, we take a full series of digital photographs at n 3D representation of your mouth that we are able to share with y seeing in your mouth. It is an important tool for discussion of tre allows us to share with the labs what we see, so that they can m surrounding teeth to give you the best cosmetic results.	you so that you can see what we are attment needed for our patients. It also
I hereby give my consent for Drs. Chin & Pharar to take photo face, jaw, and teeth.	graphs, slides and/or videotape of my
I understand that some of these images may be used by laborate bridges, or dentures and these images will become part of my de	
I do not expect compensation, financial or otherwise, for the use	of these images.
I understand that the information disclosed under this authorization longer protected by the federal privacy regulations. I understand authorization and that my refusal to sign will not affect my ability or eligibility for benefits. Finally, I understand that I may revoke sending a letter to my dental care provider stating my revocation extent that action has been taken in reliance on this authorization authorization expires 10 years from the date I sign below.	that I may refuse to sign this to obtain treatment, payment, enrollment, this authorization in writing at any time by and the effective date, except to the
Patient's or Legal Guardian's/Representative's Signature	Date
Dentist's Signature	Date

<u>Please Read Our Office Procedure Below & Complete the Credit Card Authorization Form.</u>

Like in fine hotels we make your visit as pleasurable and effortless as possible. In order to provide this service to you we ask that you keep a debit or credit card on file. We assure you our office records are secure and private.

This benefits you by allowing us to bill your insurance for services and not require full payment on the date of service. We only ask you for an estimated portion at the time of treatment. We will do our best to maximize your benefits, but the insurance company will not guarantee any payments until they are received. Upon receiving the insurance payment we will then credit your card with any overpayment of insurance or debit your card for any small remaining balance. This allows you to receive an instant refund if applicable and allows us to keep your dental fees lower by eliminating the cost of billing. This also benefits you, if you have forgotten your pocket book/wallet. We then can use your card on file for treatment instead of rescheduling your appointment or having a family member bring your payment to the office.

Some of our patients prefer to not keep a credit card on file and pay in full at time of visit and have insurance benefits sent directly to them. We will be happy to submit insurance forms on your behalf for dental benefits.

Please let us know what form of payment you will be using by circling one.

<u>Card on File</u> or <u>Payment in Full</u>

Name on Card:				
Card Number:				
Billing Address:				
Type of Credit Card:	Amex	MasterCard_	Visa	_ Discover
Expiration Date:	Sec	urity Code On E	Back of Ca	ard:
Signature of Approva	1:			
We will send a copy of	of your rec	eipt for any tran	saction tl	hat applies. Tha