HippDentistry

## PATIENT REGISTRATION - ADULT

**First Name** _____ **Last Name** _____ **M.I.** _____

**Address** _____ **City** _____ **State**_____ **Zip Code** _____
(no P.O. boxes please)

**Home Phone** _____ **Cell** _____ **Work** _____ **Text:** Y **or** N

**Email Address** _____ **Email:** Y **or** N

**Date of Birth** _____/_____/_____ **Social Security #** _____- _____- _____

**Drivers License No.** _____

**Please Circle One:** Married Single Divorced Widowed

**Preferred Pharmacy**_____ Address: _____

## DENTAL INSURANCE INFORMATION

**Primary Insurance**
Insurance Company Name: _____ Insured's Name: _____

Insured's Address: _____ City/State/Zip:_____

Insured's Date of Birth: _____/_____/_____ Insured's Social Security # _____-_____-_____

Employer _____ Employer Address _____

**Secondary Insurance**
Insurance Company Name: _____ Insured's Name: _____

Insured's Address:_____ City/State/Zip: _____

Insured's Date of Birth: _____/_____/_____ Insured's Social Security # _____-_____-_____

Employer _____ Employer Address _____

**Who may we thank for referring you to our office?** (if a person referred you, please write their name so we may thank them)

Current Patient: Sign Insurance Internet Social Media Other: _____

## OFFICE POLICIES

Thank you for choosing our practice to serve your dental needs. Please take the time to read and initial each section and sign and date the bottom of this form.

_____ Full payment is due at the time of service unless arrangements have been made prior to the start of any treatment.

_____ Insurance balances are ultimately the patient's obligation. We file most primary insurances at no cost to you as a courtesy. However, insurance balances which are not paid within 60 days may be billed to you. Please keep your walk-out statements and follow up with your insurance carrier to ensure prompt payment.

_____ Some of your treatment may <u>not</u> be covered by your insurance carrier. The cost for such charges will be your responsibility.

_____ Major services may require a deposit equal to at least one half of the estimated patient portion at the time the appointment is made.

_____ Patients are asked to confirm their appointments at least 24 hours in advance by directly contacting our office or by responding to our confirmation contact (email or text). Failure to confirm your appointment may result in a financial charge for the time reserved.

_____ There will be a fee of $30.00 for any checks returned as Non-Sufficient Funds (NSF).

_____ Patient balances that go unpaid for 90 days or more may incur one or more of the following charges:

- *Interest charges for 1.5% per month*
- *18% APR collection fees (up to 25% of the full balance)*
- *Legal fees for collection services*

_____ If you choose to pay with a credit or debit card, an additional convenience fee will be added to your total balance. *(HSA cards are exempt from the convenience fee)*

## PHOTOGRAPHY RELEASE

I, _____ authorize Evan Hipp DMD, PC to take photographs, slides, and/or videos of my face, jaws, and teeth. I understand that the photographs, slides, and/or videos will be used as a record of my care, and may be used for educational purposes in lectures, demonstrations, advertising (including website publication, newspapers, magazines, television), professional publications (dental magazines and journals, and/or social media (Facebook, etc.). I further understand that my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs.

## ACKNOWLEDGMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

I, _____ have reviewed a copy of this office's Notice of Privacy Practices.
*I have had full opportunity to read and consider the contents of this office's policies and Notice of Privacy Practices. I understand that I am giving permission to use and disclose my protected health information to use in treatment, payment activities, and healthcare operations. I also understand that I have the right to revoke or modify this permission.*

**To give consent to disclose healthcare information to someone other than the patient, please write their name and relationship to the patient below.**

Name: _____
Relationship to patient: _____

_____

Signature of Patient/Parent or Legal Guardian Date

# DENTAL HISTORY

What is the reason for your visit today? _____

What is the date of your last dental visit? _____ Cleaning _____ X-rays _____

Previous Dentist's name: _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ Floss? _____

Do you have a dental problem now? Yes _____ No _____

If yes, please explain _____

**Are any of your teeth sensitive to:**

| | | |
|---|---|---|
| Hot or cold | Yes | No |
| Sweets | Yes | No |
| Biting or chewing | Yes | No |

**Do you experience any of the following:**

| | | |
|---|---|---|
| Mouth odors or bad taste | Yes | No |
| Frequent fever blisters | Yes | No |
| Bleeding or hurting gums | Yes | No |
| Do you notice any loose teeth? | Yes | No |
| Food getting caught between your teeth? | Yes | No |

If so, where _____

**Do you:**

| | | |
|---|---|---|
| Grind your teeth (awake/sleep) | Yes | No |
| Bite your lips or cheeks regularly | Yes | No |
| Mouth breathe (awake/sleep) | Yes | No |
| Snore or have a sleep disorder | Yes | No |

**Have you ever had:**

| | | |
|---|---|---|
| Orthodontic treatment | Yes | No |
| Oral Surgery | Yes | No |
| Periodontal treatment | Yes | No |
| A bite plate or mouth guard | Yes | No |

**Have you experienced:**

| | | |
|---|---|---|
| Clicking or popping of the jaw | Yes | No |
| Pain (joint, ear, side of face) | Yes | No |
| Difficulty opening/closing | Yes | No |
| Difficulty chewing on either side | Yes | No |
| Headaches, neck aches | Yes | No |
| Sore muscles | Yes | No |

**Are you satisfied with your teeth's appearance?**
Yes No

**Would you like to keep your teeth for a lifetime?**
Yes No

**Do you feel nervous about having dental work?**
Yes No

If so, what is your biggest concern?
_____

**Have you ever had an upsetting dental experience?**

If yes, please describe:
_____
_____

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

_____

_____

**Patient Signature** _____ **Date** _____

# MEDICAL HISTORY

**Patient Name: _____ Birth Date: _____/_____/_____**

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 that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions

| | | | |
|---|---|---|---|
| Are you under a physician's care now? | Yes | No | Name of Family Physician: |
| Have you ever been hospitalized or had a major operation? | Yes | No | If yes, please explain: |
| Have you ever had a serious head or neck injury? | Yes | No | If yes, please explain: |
| Are you taking any medications, pills, or drugs? | Yes | No | If yes, please list medications: |
| Have you ever taken Phen-Fen or Redux? | Yes | No | If yes, please list medications: |
| Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? | Yes | No | If yes, please list medications: |
| Are you aware of any allergic (or adverse) reaction to any medication or substance? | Yes | No | If yes, please explain: |
| Are you on a special diet? | Yes | No | If yes, please explain: |
| Do you use tobacco? | Yes | No | |

**WOMEN:** Are you pregnant/trying to get pregnant? Y or N Taking Oral Contraceptives? Y or N Nursing? Y or N

**Are you allergic to any of the following?**

Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa Drugs

Other If yes, please explain: _____

| **Do you have, or have you had, any of the following?** | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| A.I.D.S | Yes | No | Cortisone Medication | Yes | No | Hepatitis A, B, C | Yes | No | Renal Dialysis | Yes | No |
| HIV positive | Yes | No | Diabetes | Yes | No | Herpes | Yes | No | Rheumatic Fever | Yes | No |
| Alzheimer's Disease | Yes | No | Drug Addiction | Yes | No | High Blood Pressure | Yes | No | Shingles | Yes | No |
| Anemia | Yes | No | Easily Winded | Yes | No | High Cholesterol | Yes | No | Sickle Cell Disease | Yes | No |
| Angina | Yes | No | Emphysema | Yes | No | Hives or Rash | Yes | No | Sinus Trouble | Yes | No |
| Arthritis/Gout | Yes | No | Epilepsy or Seizures | Yes | No | Hypoglycemia | Yes | No | Spina Bifida | Yes | No |
| Artificial Heart Valve | Yes | No | Excessive Bleeding | Yes | No | Irregular Heartbeat | Yes | No | Stomach Disease | Yes | No |
| Artificial Joints | Yes | No | Excessive Thirst | Yes | No | Kidney Problems | Yes | No | Stroke | Yes | No |
| Asthma | Yes | No | Fainting or Dizzy Spells | Yes | No | Leukemia | Yes | No | Swelling of Limbs | Yes | No |
| Blood Disease | Yes | No | Frequent Cough | Yes | No | Liver Disease | Yes | No | Thyroid Disease | Yes | No |
| Blood Transfusion | Yes | No | Frequent Diarrhea | Yes | No | Low Blood Pressure | Yes | No | Tonsillitis | Yes | No |
| Breathing Problems | Yes | No | Genital Herpes | Yes | No | Lung Disease | Yes | No | Tuberculosis | Yes | No |
| Bruise Easily | Yes | No | Glaucoma | Yes | No | Mitral Valve Prolapse | Yes | No | Tumors or Growths | Yes | No |
| Cancer | Yes | No | Hay Fever | Yes | No | Osteoporosis | Yes | No | Ulcers | Yes | No |
| Chemotherapy | Yes | No | Heart Attack/Failure | Yes | No | Pain in Jaw Joints | Yes | No | Venereal Disease | Yes | No |
| Chest Pain | Yes | No | Heart Murmur | Yes | No | Parathyroid Disease | Yes | No | Yellow Jaundice | Yes | No |
| Cold Sore/Fever Blister | Yes | No | Heart Pacemaker | Yes | No | Psychiatric Care | Yes | No | | | |
| Congenital Heart Disease | Yes | No | Heart Trouble/Disease | Yes | No | Radiation Treatment | Yes | No | | | |
| Convulsions | Yes | No | Hemophilia | Yes | No | Recent Weight Loss | Yes | No | | | |

**Do you now have or have you had any disease, condition, or problem not listed above?** Y or N
If yes, please list: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that 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.

**Patient Signature_____ Date: _____**