

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.

<p>Section 2</p> <p>Employment Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired Student Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time Medicaid ID: _____ Pref. Dentist: _____ Employer ID: _____ Pref. Pharmacy: _____ Carrier ID: _____ Pref. Hyg: _____</p>	<p>Section 3</p> <p>Referred By _____ Previous Dentist _____ Emergency Contact _____ Emergency Contact # _____</p>
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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: _____

Patient Name:

Birth Date:

Date Created:

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, c

Are you under a physician's care now? Yes No If yes

Have you ever been hospitalized or had a major operation? Yes No If yes

Have you ever had a serious head or neck injury? Yes No If yes

Are you taking any medications, pills, or drugs? Yes No If yes

Do you take, or have you taken, Phen-Fen or Redux? Yes No If yes

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No If yes

Are you on a special diet? Yes No

Do you use tobacco? Yes No

Do you use controlled substances? Yes No If yes

Women: Are you...

Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic
 Metal Latex Sulfa Drugs Local Anesthetics

Other? If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No	Hemophilia <input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No	Diabetes <input type="radio"/> Yes <input type="radio"/> No	Hepatitis A <input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No	Drug Addiction <input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No
Anemia <input type="radio"/> Yes <input type="radio"/> No	Easily Winded <input type="radio"/> Yes <input type="radio"/> No	Herpes <input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No
Angina <input type="radio"/> Yes <input type="radio"/> No	Emphysema <input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Rheumatism <input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No	High Cholesterol <input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No	Hives or Rash <input type="radio"/> Yes <input type="radio"/> No	Shingles <input type="radio"/> Yes <input type="radio"/> No
Artificial Joint <input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No
Asthma <input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No
Blood Disease <input type="radio"/> Yes <input type="radio"/> No	Frequent Cough <input type="radio"/> Yes <input type="radio"/> No	Kidney Problems <input type="radio"/> Yes <input type="radio"/> No	Spina Bifida <input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No	Leukemia <input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No
Breathing Problems <input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No	Liver Disease <input type="radio"/> Yes <input type="radio"/> No	Stroke <input type="radio"/> Yes <input type="radio"/> No
Bruise Easily <input type="radio"/> Yes <input type="radio"/> No	Genital Herpes <input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No
Cancer <input type="radio"/> Yes <input type="radio"/> No	Glaucoma <input type="radio"/> Yes <input type="radio"/> No	Lung Disease <input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No
Chemotherapy <input type="radio"/> Yes <input type="radio"/> No	Hay Fever <input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No	Tonsillitis <input type="radio"/> Yes <input type="radio"/> No
Chest Pains <input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No	Osteoporosis <input type="radio"/> Yes <input type="radio"/> No	Tuberculosis <input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No	Heart Murmur <input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No	Ulcers <input type="radio"/> Yes <input type="radio"/> No
Convulsions <input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No	Venereal Disease <input type="radio"/> Yes <input type="radio"/> No
			Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No

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

Comments:

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.

Signature of Patient, Parent or Guardian:

X

Date: _____

CONSENT FOR COMMUNICATION

Patient Name: _____

Parent/Guardian Name (if patient is under 18): _____

I understand that my healthcare information is protected. I understand that in order for D3 Dentistry to leave detailed messages containing specific dental information, I need to give permission for D3 Dentistry to do so.

I consent to receive (please choose all that apply):

- Text**
 - Email**
 - Voice Message**
 - NONE**
- Cell Number:** _____
- Email Address:** _____
- Phone Number (if different from cell):** _____

Regarding the following:

- Appointment Reminders/Recall Visits
- Information regarding billing/insurance/cost estimates
- Needed Treatment/Completed Treatment
- Requests for Patient Satisfaction Reviews

Consent for Shared Information with Family & Friends

Under the HIPAA Privacy Law we are permitted and we may make a professional judgment that certain disclosures are in your best interests even without this signature. I understand that information is limited to verbal discussions and that no paper copies of my protected healthcare information will be provided without my signature on a Release of Information Form.

The name(s) listed below are family members or friends to whom I grant permission for Dr. Damian Dachowski and his representatives at our office to verbally discuss my care using their best judgment and grant them permission to disclose dental information that is relevant to my care or relevant for payment.

NAME	RELATIONSHIP	PHONE NUMBER
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Regarding the following:

- Appointment Reminders/Recall Visits
- Information regarding billing/insurance/cost estimates
- Needed Treatment/Completed Treatment

It will be my responsibility to keep this information up to date, as I recognize that relationships and friendships may change over time. This consent will be considered valid until such time that I revoke it in writing. I reserve the right to revoke it at any time.

Signature (Parent/Guardian signature if patient is under 18): _____

Date: _____

Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

D3 Dentistry
3660 Bessemer Rd.
Mt. Pleasant, SC 29466

Acknowledgement

I, _____, hereby acknowledge that I have received and reviewed a copy of [D3 Dentistry]'s *HIPAA Notice of Privacy Practices*.

I understand that [D3 Dentistry]'s *HIPAA Notice of Privacy Practices* may change periodically and that I am entitled to receive a copy of [D3 Dentistry]'s revised *HIPAA Notice of Privacy Practices* upon request.

I understand that, if I have questions about [D3 Dentistry]'s *HIPAA Notice of Privacy Practices*, I may contact [Damian Dachowski at 1-215-880-0473].

I understand that it is my right to refuse to sign this Acknowledgement should I so choose, and that [D3 Dentistry] will not refuse treatment to me if I refuse to sign this Acknowledgement.

I further understand that I may contact the Secretary of the U.S. Department of Health and Human Services should I have concerns regarding [D3 Dentistry]'s privacy policies and procedures. For information on how to contact the U.S. Department of Health and Human Services, please ask [Damian Dachowski], noted above, for assistance.

Patient Signature	Date
Signature of Personal Representative	Print Name of Personal Representative
	Relationship of Personal Representative to Patient

FOR OFFICE USE ONLY

[D3 Dentistry] made a good-faith effort to obtain Acknowledgement, from the patient noted above, of receipt of its *HIPAA Notice of Privacy Practices*. In spite of these efforts, [D3 Dentistry] was unable to obtain a signed Acknowledgement for the following reason(s):

- Refusal to sign Acknowledgement on _____, 20_____.
- Communications barriers prohibited us from obtaining a signed Acknowledgement.
- An emergency situation prohibited us from obtaining a signed Acknowledgement.
- Other (Describe): _____

Date Received	By	Patient ID

Missed Appointment Policy

Your commitment to yourself and to us is to KEEP YOUR SCHEDULED APPOINTMENT. As always we will make every effort to accommodate your scheduling needs and keep our schedule on time. In return, we ask that you help us by keeping your scheduled appointments and by notifying us **24 HOURS IN ADVANCE IF YOU ARE UNABLE TO DO SO.**

Consider your appointment with Dr. Dachowski as your personal reservation. And, as with all reservations you make (such as airline or hotel), there must be a cancellation policy.

CANCELLATION/MISSED RESERVED APPOINTMENT POLICY

As a courtesy to you, we will make every effort to confirm your reserved appointment. But, please do not consider it our responsibility to do so. If our attempts are unsuccessful, it is still your responsibility to keep your reserved appointment or contact us **24 hours** in advance to change or cancel the reserved time. **Cancellations are requested with 24 hours notice, otherwise it is concerned a missed appointment.**

First missed appointment – We realize patients get sick, people sometimes forget, or another emergency arises. As soon as you are aware that you can't make the appointment, call us – even late at night you are able to leave a message on our answering machine. Typically, we don't charge for the first missed appointment; however, we do reserve the right to do so.

Second missed appointment – A missed appointment **fee of \$50.00** will be charged to your account. This will be charged per family member if multiple appointments scheduled and broken. Please note: Insurance will not pay for this charge and is your responsibility to pay. Fee shall be waived only for unforeseen circumstances at Dr. Dachowski's discretion. . The charge will have to be paid in full before scheduling another appointment.

If missed appointments become repeated, any future appointments will require a credit card number to be kept on file and used immediately for a missed appointment fee.

Thank you for your courtesy.

Patient Name: _____

Signature (If patient is under 18, parent/guardian signature is required): _____

Date: _____