PATIENT REGISTRATION

Patient Information

First Name: ______________________________ Last Name: ______________________________ Middle Initial: ________

Returning Patient? Previous Names: ____

Preferred Name: ______________________________________ Spouses Name: ___________________________________

Address: ____ City, State, Zip: _____________________________________

Home Phone: ________________ Work Phone: ________________ Ext: __________ Cell Phone: ________________

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐Divorced ☐ Widowed

Birth Date: ____________________________________ Soc Sec: ____________________________________

E-mail: ____ ☐ I would like to receive correspondences via e-mail

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Self Employed ☐ Homemaker ☐ Other ☐ Student

Employer: ____ City, State: ______________________________________

Preferred Pharmacy: ☐ Holder Drug ☐ Alva Wal-Mart ☐ Kiowa Prescription ☐ Hibbard's ☐ Jerry's Pharmacy
☐ Smith Drug ☐Other: ____

How did you hear about our office? ☐ Referral ☐ Radio ☐ Newspaper ☐ Website ☐ Newspaper ☐ Facebook
☐ Rialto ☐ El Maya ☐ Other: ____

Please provide us with the name of the person who referred you, so we can thank them: ___________________________

What is the primary reason, or concern, for you coming to our office today? ______________________________
____
____.

Are you concerned with the appearance of your teeth? If so, if you had a magic wand, what would you like to change? ____
____
____.

Responsible Party (if someone other than the patient)

First Name: ______________________________ Last Name: ______________________________ Middle Initial: ________
Address: ____ Address 2: ____
City, State, Zip: ____ Cell Phone: ________________________________
Home Phone: ___________________________ Work Phone: ___________________________ Ext: ____________
Birth Date: ____________________________________ Soc Sec: ____________________________________

MEDICAL INFORMATION

Patient Name: ____ Date: ________________________

Who is your regular Physician? ___________________________ Physician's City, State: _________________________
Are you undergoing any type of treatment now? ____
Please list all medications you are taking: ____

____

Do you use tobacco? ☐ Smoke ☐ Smokeless ☐ No, I do not use tobacco
Do you use controlled substances? ☐ Yes ☐ No
Are you pregnant? ☐ Yes ☐ No
Are you trying to get pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

Allergies: ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex
☐ Other Allergies: ____

Do you have, or have you had, any of the following? (Check the ones you have or have had)

☐ AIDS or HIV **(please circle one if yes)**	☐ Chest Pains	☐ Frequent Headaches	☐ Irregular Heartbeat	☐ Scarlet Fever
☐ Alzheimer's Disease	☐ Cold Sores	☐ Genital Herpes	☐ Kidney Problems	☐ Shingles
☐ Anaphylaxis	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Leukemia	☐ Sickle Cell Disease
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Liver Disease	☐ Sinus Trouble
☐ Angina	☐ Cortisone Med	☐ Heart Attack/Failure	☐ Low Blood Pressure	☐Spina Bifida
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur	☐ Lung Disease	☐ Intestinal Disease
☐ Artificial Heart Valve What year:	☐ Drug Addiction	☐ Heart Pace Maker	☐ Mitral Valve	☐ Stroke
☐Artificial Joints/Hips What year:	☐ Easily Winded	☐ Heart Trouble or Heart Disease	☐ Pain in Jaw Joint	☐ Swelling of Limbs
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Parathyroid Disease	☐Thyroid Disease
☐ Blood Disease	☐ Epilepsy/Seizures	☐ Hepatitis A	☐ Psychiatric Care	☐Tonsillitis
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Radiation	☐Tuberculosis
☐ Breathing Problems	☐ Excessive Thirst	☐ Herpes	☐ Recent Weight Loss	☐Tumors/Growths
☐ Bruise Easily	☐ Fainting	☐ High Blood Pressure	☐ Renal Dialysis	☐Ulcers
☐ Cancer	☐ Frequent Cough	☐ Hives or Rash	☐ Rheumatic Fever	☐Venereal Disease
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hypoglycemia	☐ Rheumatism	☐Yellow Jaundice

Do you have any serious illness not listed above? ____

BISPHOSPHONATE DRUGS (Please circle the prescriptions listed below that you are taking or have ever taken.)
Actonel Alendronate ArediaAtelviaAvastin Bevacizumab **Boniva**
DidronelEtidronate**Fosamax**IbandronatePamidronate**ProliaReclast**RisedronateSkelid Tiludronate ZoledronateZometa**XGeva**
If yes to any of these, is it by injections and when was your last treatment? _________________
☐ I am not, and have never taken any of these medications

____ _____________________________
Signature of Patient, Parent, Guardian, or Personal Representative Date Signed

Patient Name: ____

CONSENT FOR USE & DISCLOSURE OF HEALTH INFORMATION

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide when to sign this consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to our office. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if your revoke this Consent.

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care options.

Signature: ____ Date: ____________________

OFFICE GUIDELINES & FINANCIAL POLICY

Thank you for choosing our office. Our primary mission is to become Partners with our Patients. We strive to provide the best and most comprehensive dental care available. An important part of our mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment arrangements suitable for any budget.

Your Payment Options:

(1) Cash, Check, Money Order, Discover, Visa, or MasterCard

(2) We offer a 5% courtesy discount to patients who pay for their treatment upfront with cash or check for treatment totaling over $2500.

(3) Extended payments up to (90) days in the form of post dated checks.

(4) No interest payment plans from CareCredit for more than 90 days (based on credit approval)

- **Allows you to pay over time with no interest**
- **Convenient, low monthly payment plans also available**
- **No annual fees or pre-payment penalties**

- Dr. Larry G. Smith, D.D.S., Inc. requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete (which we do not recommend), you will receive a refund less the cost of care received.
- For patients with dental insurance, we are happy to work with your carrier to maximize your benefits and directly bill them for reimbursement for your treatment. **Your estimated portion is due at the time of the appointment.**
- A fee of $25 is charged to patients who miss or cancel more than one time in a calendar year without 24-hour notice.
- A $25 charge will be applied to your account for return checks.

By signing below, I am stating that I have read, acknowledged, and agree to the above stated guidelines and policies.

Signature: ____ Date: ____________________