Coastal Valley Dental

PATIENT REGISTRATION

Name: ______________________________ Date: ______________
First MI Last

Address: ______________ City: ______________ State: _____ Zip: _____

Email: ______________ Cell Phone: ______________ Home Phone: ______________

SS#/SIN: ______________ Birthdate: ______________

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If college student, F.T./P.T Name of School: ______________ City: ______________ State: _____

Patient's or Parent/Guardian's Employer: ______________ Work Phone: ______________

Business Address: ______________ City: ______________ State: _____ Zip: _____

Spouse or Parent's/Guardian's Name: ______________ Employer: ______________ Work Phone: ______________

Whom may we thank for referring you? ______________

Person to contact in case of an emergency: ______________ Phone: ______________

Responsible Party:

Name of Person Responsible for this Account: ______________ Relationship: ______________

Address: ______________ Home Phone: ______________

Driver's License #: ______________ Birthdate: ______________ SS#/SIN: ______________

Employer: ______________ Work Phone: ______________

Is this person currently a patient in our office? ☐ Yes ☐ No

Insurance Information:

Name of Insured: ______________ Relationship to patient: ______________

Birthdate: ______________ SS#/SIN ______________ Date Employed: ______________

Name of employer: ______________ Work Phone: ______________

Employer Address: ______________ City: ______________ State/Zip: ______________

Primary Insurance:

Insurance Company: ______________ Tel #: ______________

Insurance Address: ______________ City: ______________ State/Zip: ______________

Subscriber ID #: ______________ Group #: ______________

Secondary Insurance:

Name of Insured: ______________ Relationship to patient: ______________

Birthdate: ______________ SS#/SIN: ______________ Date Employed: ______________

Name of employer: ______________ Work Phone: ______________

Employer Address: ______________ City: ______________ State/Zip: ______________

Insurance Company: ______________ Tel #: ______________

Insurance Address: ______________ City: ______________ State/Zip: ______________

Subscriber ID #: ______________ Group #: ______________

Coastal Valley Dental

MEDICAL HISTORY

Patients Name: ______________________ **Date of Birth:** ______________

Physicians Name: ______________________ **Phone Number:** ______________
Address: ______________________ **Date of last Physical Exam:** ______________

Reason for this visit: ______________________
When was your last dental visit: ______________ What was done then? ______________
How often did you visit the dentist before then? ______________________
Previous Dentist (Name & Location): ______________________
Have you had a complete series of dental films (x-rays) taken when/where? ______________

Question		Question	
Are you in good health?	☐ Yes ☐ No	Have you taken Fen-Phen/Redux?	☐ Yes ☐ No
Have there been any changes in your general health within the past year?	☐ Yes ☐ No	Have you ever taken Fosamax, Boniva, Actonel or and cancer medications containing bisphosphates?	☐ Yes ☐ No
Are you now under the care of a Physician?	☐ Yes ☐ No	Have you ever taken Viagra, Revatio, Cialis or Levitra in the last 24 hours?	☐ Yes ☐ No
Have you had abnormal bleeding?	☐ Yes ☐ No	Do you use tobacco?	☐ Yes ☐ No
Do you bruise easily?	☐ Yes ☐ No	Do you or have you used controlled substances?	☐ Yes ☐ No
Do you have any disease, condition or problem not listed above that you think I should know about?	☐ Yes ☐ No		

Have you been hospitalized for any surgical operation or serious illness? ☐ Yes ☐ No
If yes, please explain: ______________________
Are you taking any medicine(s) including non-prescription medicine? ☐ Yes ☐ No
If yes, please explain: ______________________

Women Only:
Are you pregnant or think you may be pregnant? ☐ Yes ☐ No **Are you nursing?** ☐ Yes ☐ No
Are you taking birth control pills? ☐ Yes ☐ No

Are you Allergic to or have you had reactions to:

☐ **Local Anesthetics like Novocain** ☐ **Penicillin or other Antibiotics** ☐ **Sulfa Drugs** ☐ **Aspirin** ☐ **Iodine**
☐ **Barbiturates, Sedatives or Sleeping pills** ☐ **Any Metals (E.G., Nickel, Mercury, Etc.)** ☐ **Latex**
☐ **Other (Please List):** ______________________

Do you have or have you ever had the following:

Condition			Condition			Other:
Heart Trouble, Heart Attack or Aingina	Yes	No	AIDS/HIV Infection	Yes	No	
Chest Pain	Yes	No	Joint Replacement	Yes	No	
Heart Murmur or Heart Defect	Yes	No	Cold Sores/Blister	Yes	No	
Pacemaker	Yes	No	Kidney Trouble	Yes	No	
High/Low Blood Pressure	Yes	No	Tuberculosis	Yes	No	
Congenital Heart Problems	Yes	No	Chemotherapy	Yes	No	
Hepatitis	Yes	No	Epilepsy/Seizures	Yes	No	
Stroke	Yes	No	Tumors	Yes	No	
Sinus Trouble	Yes	No	Mental Health Care	Yes	No	
Lung or Breathing Problems	Yes	No	Back Problems	Yes	No	
Asthma	Yes	No	Chemical Dependency	Yes	No	
Fainting or dizzy spells	Yes	No	Eating Disorders	Yes	No	

Authorization and Release: I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

X______________________ Date: ______________
Signature of Patient or Parent/Guardian if Minor

Financial/HIPPA/Patient Release

Thank you for choosing Coastal Valley Dental. We appreciate the opportunity to care for you and your family's dental needs. We are pleased to help you with your insurance (if applicable); however, you are ultimately responsible for payment of your bill. The following information is provided to answer questions and avoid confusion regarding payment for dental services.

Authorization to release information: I hereby authorize the release of my Protected Health Information (PHI) acquired in the course of my examination or treatment (typically x-rays, but could include health history, diagnosis, treatment or payment records), via electronic transmission, including emails with our special encryption, to my insurance company to secure payment for services or to other dental providers required to participate in my care. I further authorize the below named parties have access to my PHI and do acknowledge any party providing insurance coverage or financial responsibility will have access to my PHI.

Please circle: Spouse / Parent / Child / Other ________________

Signature of Patient/Legal Guardian: ____________________________ Date: ______________

Acknowledgement of receipt of Notice of Privacy Practice AND Notice of Material: I hereby acknowledge that the Notice of Privacy Practices and Material Data is posted at the location in which I am receiving treatment and that I have read and understand the notice. I further acknowledge that I have the right to request a copy of the notice and one will be provided to me

Signature of Patient/Legal Guardian: ____________________________ Date: _____________

Financial Responsibility:

I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier my pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or dependents.

For patients *with dental benefits:* As a courtesy, our office will file your claim with your insurance company and work with the company to provide the necessary information to maximize your benefits. Any amount not received from your insurance company is your responsibility. All copays are due on the day of treatment.

For patients *without dental benefits:* If you do not have dental insurance, you will be responsible for the full cost of your treatment. Payment for services is due at the time of treatment.

We accept cash, personal checks, and the following credit cards: Visa, MasterCard, American Express and Discover. We also offer Care Credit.

Appointments missed or cancelled less than 48 hours in advance will possibly be charged a $75 fee.

Signature of Patient/Legal Guardian: ____________________________ Date: ______________