TIME 11:47 AM

DATE 8/24/2012

PATIENT REGISTRATION

ID: _____ Chart ID: _____

First Name: _____ Last Name: _____ Middle Initial: _____

Patient Is: ☐ Policy Holder Preferred Name: _____

☐ Responsible Party

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.

Section 2

Employment Status: ○ Full Time ○ Part Time ○ Retired

Student Status: ○ Full Time ○ Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

Section 3

Referred By: _____

Previous Dentist: _____

Emergency Contact: _____

Emergency Contact #: _____

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: _____.00 Rem. Deduct: _____.00

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: _____.00 Rem. Deduct: _____.00

Drs. Chin _Pharar

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.

Height :

Weight :

Are you under a physician's care now? If so for what reason and for how long ?	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 or for Osteoperosis ?	Yes No	If yes	
Are you on a special diet?	Yes No		
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	

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?

HIV Positive Yes No	Cortisone Medicine Yes No	Hemophilia Yes No	Radiation Treatments Yes No
Alzheimer's Disease Yes No	Diabetes Yes No	Hepatitis A Yes No	Recent Weight Loss Yes No
Anaphylaxis Yes No	Drug Addiction Yes No	Hepatitis Yes No	Renal Dialysis Yes No
Anemia Yes No	Easily Winded Yes No	Herpes Yes No	Rheumatic Fever Yes No
Angina Yes No	Emphysema Yes No	High Blood Pressure Yes No	Rheumatism Yes No
Arthritis/Gout Yes No	Epilepsy or Seizures Yes No	High Cholesterol Yes No	Scarlet Fever Yes No
Artificial Heart Valve Yes No	Excessive Bleeding Yes No	Hives or Rash Yes No	Shingles Yes No
Artificial Joint Yes No	Excessive Thirst Yes No	Hypoglycemia Yes No	Sickle Cell Disease Yes No
Asthma Yes No	Fainting Spells/Dizziness Yes No	Irregular Heartbeat Yes No	Sinus Trouble Yes No
Blood Disease Yes No	Frequent Cough Yes No	Kidney Problems Yes No	Spina Bifida Yes No
Blood Transfusion Yes No	Frequent Diarrhea Yes No	Leukemia Yes No	Stomach/Intestinal Disease Yes No
Breathing Problems Yes No	Frequent Headaches Yes No	Liver Disease Yes No	Stroke Yes No
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	Tonsillitis Yes No
Chest Pains 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
Convulsions Yes No	Heart Trouble/Disease Yes No	Psychiatric Care Yes No	Venereal Disease Yes No
Yellow Jaundice Yes 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:_____

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 practice may communicate with me electronically via text and email. Please provide your email address and cell phone number below.

Even though this office takes security seriously, I am aware that there is some level of risk that third parties might be able to read unencrypted emails.

I am responsible for providing the dental practice any updates to my email address.

I can withdraw my consent to electronic communications by calling:

702-445-7075_____

Email Address (PLEASE PRINT CLEARLY):
_____@_____ Cell phone number:_____

Patient Signature:_____

Date:_____

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:_____

Dental History

Please fill out to the best of your ability so that we can provide you 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 no charge to our patients. This gives us a 3D representation of your mouth that we are able to share with you so that you can see what we are seeing in your mouth. It is an important tool for discussion of treatment needed for our patients. It also allows us to share with the labs what we see, so that they can meet our expectations of matching surrounding teeth to give you the best cosmetic results.

I hereby give my consent for Drs. Chin & Pharar to take photographs, slides and/or videotape of my face, jaw, and teeth.

I understand that some of these images may be used by laboratories for fabrication of crows, veneers, bridges, or dentures and these images will become part of my dental record.

I do not expect compensation, financial or otherwise, for the use of these images.

I understand that the information disclosed under this authorization may be subject to redisclosure and no longer protected by the federal privacy regulations. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment, or eligibility for benefits. Finally, I understand that I may revoke this authorization in writing at any time by sending a letter to my dental care provider stating my revocation and the effective date, except to the extent that action has been taken in reliance on this authorization. Unless revoked by me, this authorization expires 10 years from the date I sign below.

Patient's or Legal Guardian's/Representative's Signature Date

Dentist's Signature Date

Please Read Our Office Procedure Below &
Complete the Credit Card Authorization Form.

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.
Card on File **or** *Payment in Full*

Name on Card: _____

Card Number: _____

Billing Address: _____

Type of Credit Card: **Amex**___ **MasterCard**____ **Visa**___ **Discover**___

Expiration Date: _____ Security Code On Back of Card: _____

Signature of Approval: _____

We will send a copy of your receipt for any transaction that applies. Thank You