PLEASANT VALLEY
DENTAL CARE

Patient Registration Form

Email:			Today's Date:
Preferred Name: ❑ Miss ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr.		Referred by:	
Name: Last First Middle		Home Phone: *include area code* ( )	Cell Phone: *include area code* ( )
Address: Mailing address		City:	State: Zip:
SS#:		Date of Birth:	Sex: M F
Employer:		Business Phone: *include area code* ( )	
Emergency Contact:	Relationship:	Home Phone: *include area code* ( )	Cell Phone: *include area code* ( )

College Student Status:	❑ Full Time	❑ Part Time	Please provide school info:	School Name:_____
Employment Status:	❑ Full Time	❑ Part Time	❑ Retired	Address:_____
Marital Status:	❑ Married	❑ Single	❑ Divorced ❑ Separated ❑ Widowed	Address 2:_____
Pref. Pharmacy:		Phone: ( )		City, State, Zip:_____

Dental Insurance Information

Primary Insurance Information

Name of Insured: _____ Relationship to Patient: ❑ 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: _____

ID#: _____ Gr#:_____

Secondary Insurance Information

Name of Insured: _____ Relationship to Patient: ❑ 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: _____

ID#: _____ Gr#:_____

PLEASANT VALLEY DENTAL CARE

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. hospitalization for illness or injury _____	☐	☐
2. an allergic or bad reaction to any of the following:	☐	☐
☐ aspirin, ibuprofen, acetaminophen, codeine		
☐ penicillin		
☐ erythromycin		
☐ tetracycline		
☐ sulfa		
☐ local anesthetic		
☐ fluoride		
☐ chlorhexidine (CHX)		
☐ metals (nickel, gold, silver, _____)		
☐ latex		
☐ nuts _____		
☐ fruit _____		
☐ other _____		
3. heart problems, or cardiac stent within the last six months ___	☐	☐
4. history of infective endocarditis _____	☐	☐
5. artificial heart valve, repaired heart defect (PFO) _____	☐	☐
6. pacemaker or implantable defibrillator _____	☐	☐
7. orthopedic implant (joint replacement) _____	☐	☐
8. high or low blood pressure _____	☐	☐
9. a stroke (taking blood thinners) _____	☐	☐
10. prolonged bleeding due to a slight cut (INR > 3.5) _____	☐	☐
11. asthma _____	☐	☐
12. breathing or sleep problems (i.e. sleep apnea, snoring, sinus)	☐	☐
13. liver disease _____	☐	☐
14. vertigo _____	☐	☐
15. kidney disease _____	☐	☐
16. diabetes (HbA1c = _____) _____	☐	☐
17. stomach or duodenal ulcer _____	☐	☐
18. thyroid, parathyroid disease, or calcium deficiency _____	☐	☐
19. digestive or eating disorders (e.g., celiac disease, gastric reflux, bulimia, anorexia) _____	☐	☐
20. osteoporosis/osteopenia (i.e. taking bisphosphonates) _____	☐	☐
21. autoimmune disease _____ (i.e. rheumatoid arthritis, lupus, scleroderma)	☐	☐
22. head or neck injuries _____	☐	☐
23. epilepsy, convulsions (seizures) _____	☐	☐
24. arthritis _____	☐	☐

	YES	NO
25. neurologic disorders (ADD/ADHD, prion disease) _____	☐	☐
26. any lumps or swelling in the mouth _____	☐	☐
27. HIV/AIDS _____	☐	☐
28. tumor, abnormal growth _____	☐	☐
29. radiation therapy _____	☐	☐
30. chemotherapy, immunosuppressive medication _____	☐	☐
31. hepatitis (type ____) _____	☐	☐
ARE YOU:		
32. presently being treated for any other illness _____	☐	☐
33. aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea) _____	☐	☐
34. taking dietary supplements _____	☐	☐
35. experiencing frequent headaches _____	☐	☐
36. a smoker, smoked previously or use smokeless tobacco ___	☐	☐
37. taking birth control pills _____	☐	☐
38. currently pregnant _____	☐	☐
39. other surgeries _____	☐	☐

CURRENT MEDICATIONS AND SUPPLEMENTS:

Drug	Purpose

Please describe any other relevant health information not covered in the questions above:

_____

_____

_____

_____

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

PLEASANT VALLEY
DENTAL CARE

HIPAA
PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to the restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this Consent.

The Consent was signed by: _____
Printed Name of Patient or Representative

_____ _____
Signature Date

Relationship to Patient
(if other than patient): _____

PLEASANT VALLEY
DENTAL CARE

Acknowledgement of Office Policies

Please Sign Our Financial, Cancellation, & Acknowledgement of Considerate Care Policies

FINANCIAL AGREEMENT:

If I ***have no*** dental insurance, then I am responsible for paying all fees in full at time of service for my treatment visits unless prior arrangements have been made.

If I ***have*** dental insurance, then I am responsible for paying all estimated copays at time of service for my treatment visits.

I understand that my dental team is providing me with **ESTIMATES** as close as possible to what my insurance is expected to cover, however I am responsible for payment *regardless* of any insurance company's arbitrary determination of benefits. I understand no one from my dental office can guarantee payment from my independent third-party insurance company.

As a courtesy, my dental office will submit claims to my insurance company on my behalf. I understand that if my insurance company has not made payment within 60 days, I will be asked to contact them myself to make sure payment is expected. I understand if payment is not received or denied I will be responsible for paying the full amount at that time. I understand balances not paid in full within 90 days of the treatment date will receive a **service charge** and be sent to a collections agency.

Payment Options:

We accept cash, checks, and most major credit cards. We also work with Care Credit so you can get the care you need, when you need it.

Insurance:

We work with and accept all PPO plans.
We are in-network providers for Delta Dental Premier and CBA Blue.

If we are not in-network providers with your insurance, your plan will still pay for some portion of the treatment costs incurred our office; however, you are responsible for paying us the difference between our fees and the reimbursements set by your plan.

If you need assistance, or have questions about your insurance policies or claims, our staff is knowledgeable and always available to help you. Our team can provide you with a complimentary benefits analysis to better understand your coverage in our office.

PLEASANT VALLEY
DENTAL CARE

Acknowledgement of Office Policies

Please Sign Our Financial, Cancellation, & Acknowledgement of Considerate Care Policies

CANCELLATION POLICY:

I understand that if I do not show up for my visit, if I am more than 15 minutes late, or if I cancel without at least 48 hours notice, a $50 missed appointment fee will be assessed to my account and no further appointments may be scheduled until it is paid in full. Further, I understand that repeated failures will result in my dismissal from the practice. While our team understands extenuating circumstances and emergencies do occur, we ask that you call our office as soon as possible so we can clarify any misunderstandings.

ACKNOWLEDGEMENT OF CONSIDERATE CARE:

I understand my dental team is committed to providing me the highest quality care in the most comfortable environment. I acknowledge that I am entitled to considerate, courteous, and respectful treatment.

I understand my dental team will ensure my appointments are scheduled within a timely manner and reasonable accommodations for emergency care will ALWAYS be provided.

I understand for the safety and protection of all, security cameras are in use throughout the office which record both visual and audio input.

I understand my team complies with all **ADA, CDC, & OSHA regulations** to provide a clean and safe environment for all dental visits.

I understand I may seek a second opinion at any time and request a copy of my digital X-rays WITHOUT incurring any additional fees.

I understand that I am entitled to **privacy** and **confidentiality** in discussions, examinations, and treatment.

Patient Signature: _____ ***Guardian Signature:*** _____

Signature Date: _____ ***Signature Date:*** _____