PATIENT REGISTRATION

First Name: _____ MI: _____ Last Name: _____

Preferred name: _____ Date of Birth: _____ Gender M or F

Responsible Party: Self ___ Other_____(Provide Name)

Contact Information:

Patient Address: _____

_____

City: _____ State: _____ Zip Code: _____

Patient Height & Weight (For patients 18 years or younger): _____

Home Phone #: _____

Cell Phone #: _____

Work Phone #: _____

Email: _____

Insurance Information:

Policy Holders Name: _____

Policy Holders ID #: (from card) _____

Social Security #: _____

Policy Holders Date of Birth: _____

Employer: _____

Insurance Co Name: _____

Insurance Co Address: _____

Insurance Co Phone #: _____

Preferences:

Dentist: Dr. Wyatt/Dr. Onley/Either (Circle One)

Hygienist: Martha Brown/Olivia Wright/Either (Circle One)

Surrey Hills Dental

D. Scott Wyatt, DDS

Financial Responsibility and Assignment of Benefits to Dentist:

I understand that I am financially responsible for services rendered by the dentist and his staff. I authorize my insurance company or third party payor, to pay benefits on my behalf directly to the dentist. I agree to be responsible for my financial portion including but not limited to copays, insurance and deductibles. I understand that in the event my insurance company denies payment for services rendered, I agree to be personally responsible for those charges incurred.

Signature Date

Release of Information:

I hereby authorize the release of any or all patient's information from Surrey Hills Dental for insurance claim purposes . If some other party is paying the patient's bill or by any contract may be expected to pay the bill, then Surrey Hills Dental may disclose any or all of the patient's information to that party to verify charges. Surrey Hills Dental may disclose any or all of the patient's information to the other dental specialists (oral surgeon's, endodontists, orthodontists, pedodontists, etc.) and other health or dental care providers who have legitimate need for such information in the care and treatment of the patient.

Signature Date

APPOINTMENT AND CANCELLATION POLICY

At Surrey Hills Dental, our goal is to provide quality dental care in a timely manner. We have implemented an appointment cancellation policy which enables us to better utilize available appointments for our patients in need of dental care.

Please be courteous and call Surrey Hills Dental if you are unable to attend an appointment for any reason. This time will be reallocated to someone who is in need of treatment.

*If it is necessary to cancel your scheduled appointment we require that you give at least 24 hours notice. If our office is not open, please leave a message on our voice mail system.

*If you fail to keep an appointment and do not notify us 24 hours in advance of your scheduled appointment, you will be charged a $50.00 no show fee. You will be personally responsible for this charge. This charge will not be billed to nor paid by your insurance company.

_____ _____

Signature Date

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient: _____

Signature: _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

ITEM 070-5962/25950 © MAY 2002

Medical History Form

Patient Name:

Date of Birth:

Sex:

Emergency Contact _____

Emergency Contact Phone _____

Emergency Contact Relationship _____

Do you have any of the following diseases or problems

Active Tuberculosis ..... Yes No

Persistent cough greater than a 3 week duration ..... Yes No

Cough that produces blood ..... Yes No

Been exposed to anyone with tuberculosis ..... Yes No

Medical History

Are you now under the care of a physician? ..... Yes No

Physician Name _____

Phone (including area code) _____

Address/City/State/Zip _____

Are you in good health? ..... Yes No

Has there been any change in your general health within the past year? ..... Yes No

If yes, what condition is being treated? _____

Date of last physical exam _____

Have you had a serious illness, operation or been hospitalized in the past 5 years? ..... Yes No

If yes, what was the illness or problem? _____

Are you taking or have you recently taken any prescription or over the counter medicine(s)? ..... Yes No

If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements

_____

Do you wear contact lenses? ..... Yes No

Joint Replacement. Have you had any orthopedic total joint (hip, knee, elbow, finger) replacement? ..... Yes No

Date _____

If yes, have you had any complications? _____

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease? Yes No

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous biphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? Yes No

Date Treatment began _____

Do you use controlled substances (drugs)? ..... Yes No

Do you use tobacco (smoking, snuff, chew, bidis)? ..... Yes No

If so, are you interested in stopping? VERY / SOMEWHAT / NOT INTERESTED _____

Do you drink alcoholic beverages? ..... Yes No

If yes, how much alcohol did you drink in the last 24 hours? _____

If yes, how much do you typically drink in a week? _____

WOMEN ONLY. Are you:

Pregnant ..... Yes No

Number of weeks _____

Taking birth control pills or hormonal replacement? ..... Yes No

Nursing? ..... Yes No

Allergies, Are you allergic to or have you had any reaction to

Local anesthetics ..... Yes No

Aspirin ..... Yes No

Penicillin or other antibiotics ..... Yes No

Barbiturates, sedatives, or sleeping pills ..... Yes No

Sulfa drugs ..... Yes No

Codeine or other narcotics ..... Yes No

Metals ..... Yes No

Latex (rubber) ..... Yes No

Iodine ..... Yes No

Hay fever/seasonal ..... Yes No

Animals ..... Yes No

Food ..... Yes No

Other ..... Yes No

If Other, please specify:

_____

Congenital Heart Disease (CHD) - Please indicate if you have had or not had any of the following:

Artificial (prosthetic) heart valve ..... Yes No

Previous infective endocarditis ..... Yes No

Damaged valves in transplanted heart ..... Yes No

Congenital heart disease (CHD) ..... Yes No

Unrepaired, cyanotic CHD ..... Yes No

Repaired (completely) in the last 6 months ..... Yes No

Repaired CHD with residual defects ..... Yes No

Other Diseases and Conditions - Please indicate if you have had or not had any of the following:

Cardiovascular disease ..... Yes No

Angina ..... Yes No

Arteriosclerosis ..... Yes No

Congestive heart failure ..... Yes No

Damaged heart valves ..... Yes No

Heart attack ..... Yes No

Heart murmur ..... Yes No

Low blood pressure ..... Yes No

High blood pressure ..... Yes No

Other congenital heart defects ..... Yes No

Mitral valve prolapse ..... Yes No

Pacemaker ..... Yes No

Rheumatic fever ..... Yes No

Rheumatic heart disease ..... Yes No

Abnormal bleeding ..... Yes No

Anemia ..... Yes No

Blood transfusion ..... Yes No

If yes, date _____

Hemophilia ..... Yes No

AIDS or HIV ..... Yes No

Arthritis ..... Yes No

Autoimmune disease ..... Yes No

Rheumatoid arthritis ..... Yes No

Systemic lupus erythematosus ..... Yes No

Asthma ..... Yes No

Bronchitis ..... Yes No

Emphysema ..... Yes No

Sinus trouble ..... Yes No

Tuberculosis ..... Yes No

Cancer/Chemotherapy/Radiation Treatment ... Yes No

Chest pain upon exertion ..... Yes No

Chronic pain ..... Yes No

Diabetes Type I or II	Yes	No	Sleep disorder	Yes	No
Eating disorder	Yes	No	Mental health disorders	Yes	No
Malnutrition	Yes	No	Specify _____		
Gastrointestinal disease	Yes	No	Recurrent infections	Yes	No
G.E. Reflux/persistent heartburn	Yes	No	Type of infection _____		
Thyroid problems	Yes	No	Kidney problems	Yes	No
Stroke	Yes	No	Night sweats	Yes	No
Glaucoma	Yes	No	Osteoporosis	Yes	No
Hepatitis, jaundice or liver disease	Yes	No	Persistent swollen glands in neck	Yes	No
Epilepsy	Yes	No	Severe headaches/migraines	Yes	No
Fainting spells or seizures	Yes	No	Severe or rapid weight loss	Yes	No
Neurological disorders	Yes	No	Sexually transmitted disease	Yes	No
If yes, please specify _____			Excessive urination	Yes	No

Premedication

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ..... Yes No

Name of physician or dentist making recommendation (include phone number) _____

Do you have any disease, condition, or problem not listed above that you think I should know about? ..... Yes No

Please explain _____

_____

Signature of Patient/Legal Guardian