# REYES FAMILY DENTAL

PATIENT NUMBER

DATE

*Thank you for choosing our office to assist you with your dental needs.*

***Please fill out this Registration Form, and don't forget to provide your signature at the end.***

Patient's name _____ Date of Birth _____

Sex:_____ Social Security Number_____

If minor, name of Legal Guardian: _____ Parent's Date of Birth _____

Home phone _____ Mobile phone _____ Work phone_____

Mailing address _____ City _____State _____

Zip _____ Email address:_____

Driver's License Number or ID#:_____

Patient's/Parent's Employer _____

Business Address: _____

Business Telephone: _____

Who is responsible for this account?_____

Method of Payment: Insurance ☐ Credit Card ☐ Cash ☐

Purpose of Today's Visit: _____

Whom may we thank for referring you to our office? _____

**INSURANCE INFORMATION**: ☐ Not covered by dental insurance

Employee Name: _____ Employee Date of Birth: _____

Employer: _____ # of Years _____

Name of Insurance Co. _____

Address: _____

Telephone: _____ Program or Policy Number: _____

Union Local or Group: _____

Patient's SS# : _____ or Member ID#_____

Dental Insurance Co._____ Group number_____ Claims Address_____

Covered by spouse's insurance? ☐yes ☐no Spouse's Name _____

Spouse's dental insurance company _____ Group number _____

Spouse's birthday _____ Spouse's SS# or Member ID# _____

Someone to Notify in Case of Emergency

Name:_____ Relationship:_____

Telephone: _____

**Are you covered by a secondary dental insurance?** ☐Not covered by additional dental insurance ☐ Yes

Employee Name: _____ Employee Date of Birth: _____

Employer: _____ # of Years _____

Name of Insurance Co. _____

Address: _____

Telephone: _____ Program or Policy Number: _____

Union Local or Group: _____

Patient's SS# : _____ or Member ID#_____

**RELEASE**:
I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.
I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.
I authorize release of any information concerning my (or my child's) health care, advice, and treatment to another dentist.
I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.
I understand that my dental care insurance carrier or payor of my dental benefits may pay less that the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payor.
I attest to the accuracy of the information in this registration form.

PATIENT/GUARDIAN SIGNATURE:_____ DATE: _____

REYES FAMILY DENTAL

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|---|---|---|---|---|---|
| | | | | | |

PATIENT NUMBER

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | - | | | - | | |

DATE

Patient's Name: _____ Date of Birth: _____
LAST FIRST INITIAL

I hereby authorize payment directly to Charles Reyes, D.D.S. of the dental benefits otherwise payable to me.

_____ _____
SIGNATURE (Insured Person) DATE

Signature is valid for two years from the above date, unless revoked by Charles Reyes, D.D.S at an earlier date

Charles Anthony Reyes, D.D.S. is authorized to provide any insurance company(ies), claim administrator(s) and consulting health care professionals, information concerning health care advice, treatment or suppliers provided. This information will be used for the purpose of evaluating and administering claims for benefits.

This authorization is valid for the term of coverage of the policy or contract, in force on this date only, or for two years, whichever is shorter.

I know I have a right to receive a copy of this authorization upon request and agree that the photographic copy of this authorization is as valid as the original.

_____ _____
PATIENT OR AUTHORIZED PERSON'S SIGNATURE DATE

| Patient Name | Date of Birth | MEDICAL HISTORY |
|---|---|---|
| Patient Account No. | | Medical Alert |

*Welcome! Please complete both sides of this dental/medical history form so that we may provide you with the best possible dental care.* **All information is completely confidential.**

Physician's Name _____
Address:_____
Are you under a physician's care? ☐ Yes ☐ No Since When? _____ Why?_____
When was your last complete physical exam? _____
Are you taking any medications or substances? ☐ Yes ☐ No If yes, please list medications:_____
_____
Do you routinely take health-related substances? ☐ Yes ☐ No
Are you allergic to any medications or substances? ☐ Yes ☐ No If yes, to which medications? _____
Do you have any other allergies? ☐ Yes ☐ No
Do you have any problems with penicillin, antibiotics, anesthetics, or other medications? ☐ No ☐ Yes
If yes, list meds:_____
Are you sensitive to any metals or latex? ☐ Yes ☐ No If yes, which one?_____

| | | |
|---|---|---|
| Are you pregnant or suspect you may be? | ☐ No | ☐ Yes |
| Do you use any birth control medications? | ☐ No | ☐ Yes |
| Have you ever been treated for or been told you might have heart disease? | ☐ No | ☐ Yes |
| Do you have a pacemaker or an artificial heart valve implant? | ☐ No | ☐ Yes |
| Have you ever had rheumatic fever? | ☐ No | ☐ Yes |
| Are you aware of any heart murmurs? | ☐ No | ☐ Yes |
| Do you have high or low blood pressure? | ☐ No | ☐ Yes |
| Have you ever had a serious illness or major surgery? | ☐ No | ☐ Yes |

If so, explain: _____

| | | |
|---|---|---|
| Have you ever had radiation treatment, chemo treatment for tumor, growth, or other condition? | ☐ No | ☐ Yes |
| Do you have inflammatory diseases, such as arthritis or rheumatism? | ☐ No | ☐ Yes |
| Do you have any artificial joints/prostheses? | ☐ No | ☐ Yes |
| Do you have any blood disorders, such as anemia, leukemia, etc.? | ☐ No | ☐ Yes |
| Have you ever bled excessively after being cut or injured? | ☐ No | ☐ Yes |
| Do you have any stomach problems? | ☐ No | ☐ Yes |
| Do you have any kidney problems? | ☐ No | ☐ Yes |
| Do you have any liver problems? | ☐ No | ☐ Yes |
| Are you diabetic? | ☐ No | ☐ Yes |
| Do you have asthma? | ☐ No | ☐ Yes |
| Do you have epilepsy or seizure disorders? | ☐ No | ☐ Yes |
| Do you currently have, or have you ever had a venereal disease? | ☐ No | ☐ Yes |
| Have you ever tested HIV positive? | ☐ No | ☐ Yes |
| Do you have AIDS? | ☐ No | ☐ Yes |
| Have you ever tested positive for hepatitis? | ☐ No | ☐ Yes |
| Do you currently have Tuberculosis, or have you ever tested positive for T.B.? | ☐ No | ☐ Yes |
| Do you smoke, chew, use snuff, or use any other form of tobacco? | ☐ No | ☐ Yes |
| Do you consume alcoholic beverages? | ☐ No | ☐ Yes |
| Do you habitually use controlled substances? | ☐ No | ☐ Yes |
| Have you had psychiatric treatment? | ☐ No | ☐ Yes |
| Have you ever taken the prescription drugs fenfluramine, fenfluramine combined with phentermine (fen-phen), dexfenfluramine (redux), or other weight loss products? | ☐ No | ☐ Yes |

Do you have any disease, condition, or problem not listed?
If so, please explain: _____
Is there anything else we should know about your health that we have not covered in this form?_____
_____
Would you like to speak to the Doctor privately about your problem?_____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT/GUARDIAN'S SIGNATURE: _____ DATE: _____

DENTIST'S SIGNATURE: _____ DATE: _____

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www.reyesfamilydental.us

REYES FAMILY DENTAL

# OFFICE POLICIES

1. Please arrive 15 minutes before appointment time for registration, update of insurance information, and to sign consent forms. Patients arriving more than 5 minutes late are considered to have lapsed their appointment. If you arrive late, do not cancel with a 24-hour notice, or do not show up for the appointment, this will count as a lapse. We only allow 2 lapses per patient. At the 2nd lapse, we will drop the patient from our office and recommend they call the Medicaid office to find another dentist. We report all of our lapses to the Medicaid office.

2. The parent/guardian listed on the Medicaid letter must accompany the child to the appointments and stay in our waiting area or treatment room throughout the appointment. Parents/Guardians are not allowed to leave children unattended if they are under the age of 18 years old.

3. Bring all info for children and parent/guardian, such as social security #, date of birth, employment info, and the name & phone number of a person that does not live with you as an emergency contact.

4. We give alternating appointments (during school hours and after-school), and if needed we will provide excuses that can be given to the attendance office at the child's school as proof.

5. There is a 24-hour answering service, and they are instructed to take any messages with regards to the appointments if necessary. If you need to contact the doctor at any time, just call the office phone number and the doctor or office manager will get back to you.

6. Parents/guardians are allowed to go into the treatment area with patient; however, there is limited space in treatment rooms, so only one parent is allowed in treatment area with patient. If parent becomes a distraction or is complicating appointment, parent may be asked to wait in lobby.

7. Please do not let children play in the hallway, or out in the parking area. There is a fire alarm and if the children set if off, then parents of those children will pay the fine of $300 for a false alarm. Do not let the children walk on the chairs in the waiting area, or change the channel on the TV. Do not bring any food or drink, and foul language will not be tolerated and you will be asked to leave.

8. If the child/children are on medications, or see a doctor on a regular basis for any medical problems, please be sure to bring name of meds, dosages, and the name and phone # of the attending doctor. Also, bring any info with regards to heart murmur given to the parent by the doctor.

_____ _____

Signature Date

APPENDIX I – Acknowledgement of Receipt of Notice of Privacy Practices and HIPAA Communication Consent Form

PATIENT NAME:_____ DATE OF BIRTH:_____

This consent form allows the Organization to use and disclose information about me protected under the Health Insurance Portability and Accountability Act of 1996. This information may be used or disclosed to carry out treatment, payment, or health care operations.

The Organization has provided me with a Notice of Privacy Practices, which more completely describes such uses and disclosures. It provided this notice prior to my signing this form in accordance with my right to review its practices before signing consent.

I understand that the terms of the Notice of Privacy Practices may change and that I may obtain revised notices by contacting the Privacy Officer at the Organization.

_____ Initial

I hereby authorize that the Organization may leave messages on my voicemail to confirm appointments, and/or may speak with other members of my household and leave messages with them regarding my appointments.

☑ Email ☑ Home Phone ☑ Office Phone ☑ Cell Phone

_____ Initial

I hereby authorize that the Organization may disclose my health information to any person(s) who accompany me to my appointment, and are present with me in the office while I meet with my dentist and staff.

_____ Initial

I hereby authorize that the Organization may disclose my personal health information to the person whom I have listed as my emergency contact.

_____ Initial

I hereby authorize that the Organization may disclose my personal health information to the following person(s):

| NAME | TELEPHONE NUMBER | RELATIONSHIP TO PATIENT |
|---|---|---|
| | | |
| | | |
| | | |

I understand that at any time, I have the right to revoke this consent, provided that I do so in writing, but that the Organization services may still use information to complete any actions that it began prior to my revoking consent and which rely on my protected health information. I understand that the Organization may refuse service if I revoke this consent.

I understand that I have the right to request – now and in the future – how protected health information is used or disclosed to carry out treatment, payment and health care operations, and must be provided by me in writing. I understand that while the Organization is not required to agree to my requested restrictions, if it does agree, it is bound by that agreement.

**By my signature below, I affirm the above information.**

**Signature of Patient** _____ **Date:** _____

**Signature of Parent/Representative (if minor)**_____ **Date:** _____