PATIENT REGISTRATION

Patient Name			Today's Date
Gender: □ M □ F	Birthdate	Social Security Number	Please check one: □ Single □ Married □ Separated □ Widowed
Home Address			
City		State	Zip Code
Cell Phone Number	Home Phone Number		Work Phone Number
Email Address		Employer	
Are you a full-time student? □ Yes □ No	If the patient is a minor, please provide mother's and/or father's birthdate(s)		
How did you hear about our office?	EMERGENCY CONTACT INFORMATION Name, telephone number, relationship to patient		
Reason for this visit			

Our goal is to always provide our patients with outstanding dental care in a timely manner. We understand that illness, emergencies, flat tires, and bad weather can occur. We ask that our patients give our office 48 hours' notice, when at all possible, if they are unable keep a scheduled appointment. This allows us time to offer a sooner appointment to other patients who may be waiting. Effective April 1, 2022, a $50 cancellation fee will be applied to missed appointments or any appointment cancelled without 48 hours' notice. We appreciate your understanding and consideration regarding our cancellation policy.

DENTAL INSURANCE INFORMATION

Subscriber's Name	Subscriber's Birthdate	Relationship to Patient: □ Self □ Parent □ Spouse □ Other
Subscriber's Employer	Insurance Carrier	
Group Number	ID Number or Subscriber's SSN	Insurance Carrier's Phone Number

Name of Previous Dental Office		Office Phone Number
Date of Last Visit	Date of Last X-rays	Date of Last Cleaning

MEDICAL HISTORY

Patient Name	Birthdate	Today's Date

Primary Physician's Name	Physician's Phone Number

Preferred Pharmacy	Pharmacy Phone Number

Do you have or have you ever had:

Abnormal Blood Pressure..... ☐ Yes ☐ No
Anxiety..... ☐ Yes ☐ No
Artificial Heart Valve/Stent..... ☐ Yes ☐ No
Artificial Joint/Pins..... ☐ Yes ☐ No
Asthma/Inhaler..... ☐ Yes ☐ No
Auto-Immune Disease..... ☐ Yes ☐ No
Cancer..... ☐ Yes ☐ No
Type of Cancer: _____
Treatment: ☐ Radiation ☐ Chemotherapy ☐ Surgery
Chemical Dependency..... ☐ Yes ☐ No
Corticosteroid Treatment..... ☐ Yes ☐ No
Diabetes..... ☐ Yes ☐ No
☐ Type I ☐ Type II · HbA1C _____%
Date last checked: _____
Epilepsy..... ☐ Yes ☐ No
Excessive Bleeding..... ☐ Yes ☐ No
Fainting Spells..... ☐ Yes ☐ No
Frequent Sinus Infections..... ☐ Yes ☐ No
Gout..... ☐ Yes ☐ No
Hearing Impairment..... ☐ Yes ☐ No
Heart Attack..... ☐ Yes ☐ No
Heart Pacemaker..... ☐ Yes ☐ No
Hepatitis B..... ☐ Yes ☐ No
Hepatitis C..... ☐ Yes ☐ No
High Adrenaline Career..... ☐ Yes ☐ No
High Cholesterol..... ☐ Yes ☐ No
HIV/AIDS..... ☐ Yes ☐ No
Hyperglycemia..... ☐ Yes ☐ No
Hypoglycemia..... ☐ Yes ☐ No
Kidney Disease..... ☐ Yes ☐ No
Lupus..... ☐ Yes ☐ No
Migraine Headaches..... ☐ Yes ☐ No
Osteoporosis/Bisphosphonate Treatment.... ☐ Yes ☐ No
Pneumonia..... ☐ Yes ☐ No
Psychiatric Care..... ☐ Yes ☐ No
Rheumatoid Arthritis..... ☐ Yes ☐ No
Sexually Transmitted Disease..... ☐ Yes ☐ No
Seizures..... ☐ Yes ☐ No
Stroke..... ☐ Yes ☐ No
Tuberculosis/Lung Disease..... ☐ Yes ☐ No

Please list any surgeries you have had including the year completed (ie: joint replacement, heart valve replacement, etc.).

_____

_____

Do you have any allergies?..... ☐ None

☐ Acetaminophen ☐ Fluoride ☐ Latex ☐ Penicillin
☐ Aspirin ☐ Gluten ☐ Local Anesthetic ☐ Sulfa
☐ Codeine ☐ Ibuprofen ☐ Metals ☐ Tetracycline
☐ Dyes Other: _____

Do you take any blood thinners, prescribed or non-prescription?..... ☐ None

☐ Aspirin ☐ Eliquis ☐ Fish Oil
☐ Coumadin ☐ Garlic ☐ Warfarin
Other: _____

Are you taking or have you ever taken oral bisphosphonates or IV bisphosphonates for osteoporosis?..... ☐ None

☐ Actonel ☐ Fosamax ☐ Prolia
☐ Aredia ☐ Reclast ☐ Zometa
☐ Boniva Other: _____

Please list any medications and supplements (prescribed and non-prescription) that you currently take.

_____

_____

_____

*Never alter any medications unless instructed by your physician.

Have you been told you need to take antibiotics prior to dental treatment?..... ☐ Yes ☐ No

Do you snore?..... ☐ Yes ☐ No
Do you feel rested upon waking?..... ☐ Yes ☐ No
Do you doze off during the day?..... ☐ Yes ☐ No

Have you been told that you stop breathing or choke/gasp in your sleep?..... ☐ Yes ☐ No

How many alcoholic beverages do you consume per week? _____ (One drink=1 beer or 5 oz wine or 1.5 oz hard liquor)

Do you or have you ever used tobacco products?..... ☐ No

☐ Chewing Tobacco ☐ Cigars ☐ Vape
☐ Cigarettes ☐ Pipe Other: _____
If yes, packs per day_____ Number of years_____ Year quit (if applicable) _____

Are you pregnant or nursing?..... ☐ Yes ☐ No

Is there anything we need to know about your health that is not listed above?..... ☐ Yes ☐ No

If so, please share_____

Have you had any dental treatment recommended in the past that has not yet been completed?..... ☐ Yes ☐ No
Have you ever been treated for periodontal/gum disease?..... ☐ Yes ☐ No
Are you concerned with grinding or clenching your teeth?..... ☐ Yes ☐ No
Do you wear a bite/night guard?..... ☐ Yes ☐ No
Are you aware of any possible TMJ problems, or does your jaw joint make noise, lock, or create pain?..... ☐ Yes ☐ No

Do you have or have you had any of the following:

☐ Bad breath
☐ Bleeding, swollen, or irritated gums
☐ Braces
☐ Broken teeth or fillings
☐ Dentures/Partials
☐ Grinding or clenching teeth
☐ Headaches, earaches, or neck pain
☐ Loose or shifting teeth
☐ Sensitivity
Where? (Circle all that apply) UR UL LR LL

Why did you leave your previous dental office?

_____

_____

What is the most important thing to you about your dental visit today?

_____

_____

_____

Patient Signature Date

_____

Provider Signature Date

_____ I authorize LifeTime Dental, Inc. doctors and designated staff to take x-rays, study models,
(Initial) photographs, or any other diagnostic aids deemed appropriate by the doctor(s) in order to make a thorough diagnosis of my dental needs. I authorize the doctor(s) and designated staff to perform all forms of treatment, medication, and therapy that may be indicated in connection with my case or my dependent's case with my consent. I understand that the use of anesthetic agents embodies a certain risk. I authorize the doctor(s) to employ such assistance as they deem fit.

I authorize LifeTime Dental, Inc. to release my personal information regarding my diagnosis, proposed, pending and/or completed treatment, billing, insurance, records and to discuss matters relating to my care to the following individuals:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

☐ No information is to be released to anyone.

*This Release of Information will remain in effect until terminated by me in writing.

This release is strictly designed to give permission to LifeTime Dental, Inc. to use my digital patient photos for their website, social media, and in-office presentation for both educational and promotional purposes. Lifetime Dental Inc. will have permission to use these photos in the manner discussed with me, unless I request the office no longer use them. I understand that by allowing LifeTime Dental Inc. to use my photos, they may share "before and after" images to educate and explain procedures and possible results of treatment. I understand that I have the option to decline this request and am not obligated in any way to provide permission to use these photos.

☐ I will allow LifeTime Dental Inc. to share my digital patient photos.

☐ I am requesting that my digital patient photos NOT be shared.

_____ I authorize LifeTime Dental to release any information including the diagnosis and records of any
(Initial) treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay any dental benefits otherwise payable to me directly to the dental practice. I understand that my insurance carrier may pay less than the anticipated amount for dental treatment. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature: _____ Date: _____

HIPAA CONSENT

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 or on our website at www.lifetimedental.us under the Patient Information tab.

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.

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices, and the patient is able to review this notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.

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).

Signature: _____ Date: _____

_____ Relationship: _____

Printed name (if other than the patient)

ACKNOWLEDGEMENT OF PRIVACY POLICIES

I,_____, have received a copy of the Privacy Practices of LifeTime Dental.

Name (Please Print)

Signature: _____ Date: _____

For office use only:

We attempted to obtain written acknowledgement of receipt of our Privacy Practices, but acknowledgement could not be obtained because:

- ○ Individual refused to sign
- ○ Communication barriers prohibited obtaining acknowledgement
- ○ An emergency situation prevented us from obtaining acknowledgement
- ○ Other (Please Specify) :_____

Staff Signature: _____