

Patient Registration

Other Dentist if applicable: _____

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

Emergency Contact: _____

Patient Information

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

Home Phone: _____ Work Phone: _____ Ext: _____ Cell Phone: _____

E-mail: _____ Preferred Name: _____

Birth Date: _____ Soc Sec #: _____ Driver's License: _____

Mailing Address: _____

City, State, Zip: _____

Married: ___ Single: ___ Divorced: ___ Separated: ___ Widowed: ___ Spouse Name: _____

Employment Status

Full Time: ___ Part Time: ___ Retired: ___

Student Status

Full Time: ___ Part Time: ___

Occupation: _____ Employer Name: _____

Preferred Hygienist: _____

Preferred Pharmacy: _____ Pharmacy Phone Number: _____

Responsible Party (If someone other than the patient)

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

Mailing Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cell Phone: _____

Birth Date: _____ Soc. Sec #: _____ Driver's License: _____

E-mail: _____

Insurance Information

Primary Policy Holder's Information

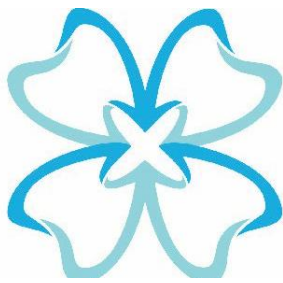
Last Name: _____ First Name: _____ Date of Birth: _____

Soc. Sec. #: _____ Employer: _____ Relationship to Patient: _____

Mailing Address (if different than patient): _____

Insurance Company: _____ Insurance Address: _____

ID Number: _____ Group/Policy Number: _____ Phone Number: _____



ORANGE BEACH
FAMILY DENTISTRY

Appointment Confirmation & Cancellation Policy

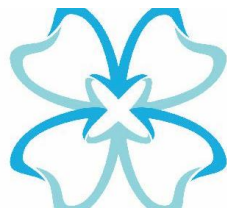
To better serve our patients we require that appointments be confirmed to keep any reserved appointment time. If you don't confirm we'll remove you from our schedule and wait to hear from you to reschedule. As a courtesy, we make multiple attempts to confirm appointments by text, email and/or phone call. It is your responsibility to notify our office of any change in contact information.

It is our policy that you call 2 business days in advance to cancel or reschedule your appointment. Failure to give 2 business days' notice could result in a \$50 charge to your account. This fee will not be billed to your insurance, and you will be expected to pay before your next appointment or, in some cases, before another appointment can be reserved.

Patient Name (print)

Patient Signature

Date



**ORANGE BEACH
FAMILY DENTISTRY**

Our Policy Regarding Dental Insurance

Our office can file almost any dental insurance, but we are only contracted with Careington Platinum and Dental Health Alliance. Please remember, the financial obligation for dental treatment is between you and this office and is not between this office and your insurance company. Though your dental insurance is your responsibility we can help! We will go the extra mile to help you maximize your benefits. As a courtesy, we will help by filing your insurance forms (when possible), which will save you considerable time and trouble. We accept payments from most insurance companies, which reduces your immediate out-of-pocket expense.

Regardless of what we may calculate your insurance company to pay, it is only an estimate. Our estimate is based on limited information obtained from your insurance company. You must understand, we cannot guarantee what they will pay.

We must stress that you are responsible for the total treatment fee. Your dental insurance is not designed to pay the entire cost of your treatment, but it is intended to help cover a certain portion of the cost. Better terms for dental insurance may be "dental assistance" or "dental benefits."

I have read and understand the above.

Print Patient Name **Patient Signature** **Date**

Information Release

For us to obtain your insurance information for submitting your claim and/or discuss your situation directly with your insurance please initial the below portion and return.

- I authorize release of any information relating to my claim.
- I authorize payment directly to Orange Beach Family Dentistry.
- I understand that all fees not paid by insurance are my responsibility.

Patient Signature

Date



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that under the HIPAA (Health Insurance Portability and Account and Ability Act of 1996), I have certain rights and 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 providers
- Conduct normal healthcare operations such as quality assessments and physician certifications

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

By signing below, I understand the Privacy Practices of Orange Beach Family Dentistry.

Patient Signature

Date

I give Orange Beach Family Dentistry permission to share my information with the following person(s) (if applicable):

FOR OFFICE USE ONLY:

Documentation of Failure to Obtain Signed Acknowledgement

Patient Name: _____

- Individual Refuses to Sign
- Communication Barriers – prohibited obtaining the acknowledgement
- Emergency – prevented us from obtaining the acknowledgement
- Other – please explain: _____

Staff Signature

Date

Patient Photo Release Form

Throughout your care, we will be taking imaging records to document the condition and progress of your care. These records may include photographs, videos, or digital scans. Orange Beach Family Dentistry attends courses with healthcare professionals and uses case studies to discuss their findings. In addition, Orange Beach Family Dentistry occasionally uses patient images to demonstrate care to existing patients or in the promotion of the office.

If you choose to allow us to use your records for these purposes, your name and other personal identifying information will be kept strictly confidential unless we have your express written consent. No compensation will be given for the use of your photographs or imaging records.

Please indicate your preference:

I authorize Orange Beach Family Dentistry to share my imaging records for research and educational purposes.

I authorize Orange Beach Family Dentistry to share my imaging records for marketing or promotional purposes.

I authorize Orange Beach Family Dentistry to use my name in conjunction with my imaging records.

OR

I do not give authorization for my imaging records to be used for any purpose other than those required for my care.

Orange Beach Family Dentistry will have permission to use these imaging records in the above manner unless I provide a written request that the office no longer use them. I understand that I have the option to decline this request and am not obligated in any way to give permission to use these images.

Patient Name - Print

Patient Signature

Date

Practice Representative Signature

Date



ORANGE BEACH
FAMILY DENTISTRY

25299 Canal Road Suite A5, Orange Beach, AL 36561

Ph: (251) 321-7575 Email: info@orangebeachfamilydentistry.com

Orange Beach Family Dentistry

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.

Are you under a physician's care now? Yes No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? Yes No

IF YES, **CIRCLE** ANY SURGICAL OPERATIONS YOU HAVE HAD:

Appendectomy	Heart	Thyroid
Back	Hernia Repair	Tonsillectomy
Ear	Lung	Uvulectomy
Gallbladder	Nasal	Periodontal
Other _____		

Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? Yes No

LIST ANY MEDICATIONS CURRENTLY BEING TAKEN

Medication Name	Dosage/Frequency	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SOCIAL HISTORY

Tobacco Use: Cigarettes Never Smoked

Current Smoker

packs per day _____

of years _____

Quit

When did you quit?

Other Tobacco Pipe Snuff Cigar Chew Vape

Do you drink alcohol? Yes No If yes, # of drinks per week: _____

Do you drink caffeine (coffee/tea/soda)? Yes No # cups per day: _____

Do you use controlled substances? Yes No

MEDICAL HISTORY

Do you need to pre-medicate? Yes No If yes, please explain: _____

Women: Are you Pregnant/Trying to get pregnant?	Yes	No	Taking oral contraceptives?	Yes	No
Nursing?	Yes	No			

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Sulfa Drugs Local Anesthetics Epinephrine Sensitivity

Other? If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Renal Dialysis	Yes	No
Alzheimer's/Dementia	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Rheumatic Fever	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Rheumatism	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Scarlet Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Shingles	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	Hives or Rash	Yes	No	Sickle Cell Disease	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hypoglycemia	Yes	No	Sinus Trouble	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Irregular Heartbeat	Yes	No	Spina Bifida	Yes	No
Asthma	Yes	No	Fainting Spells/Dizziness	Yes	No	Kidney Problems	Yes	No	Stomach/Intestinal Disease	Yes	No
Autism	Yes	No	Frequent Cough	Yes	No	Leukemia	Yes	No	Stroke	Yes	No
Blood Disease	Yes	No	Frequent Diarrhea	Yes	No	Liver Disease	Yes	No	Swelling of Limbs	Yes	No
Blood Transfusion	Yes	No	Frequent Headaches	Yes	No	Low Blood Pressure	Yes	No	Thyroid Disease	Yes	No
Breathing Problem	Yes	No	Genital Herpes	Yes	No	Lung Disease	Yes	No	Tonsillitis	Yes	No
Bruise Easily	Yes	No	Glaucoma	Yes	No	Mitral Valve Prolapse	Yes	No	Tuberculosis	Yes	No
Cancer	Yes	No	Hay Fever	Yes	No	Pain in Jaw Joints	Yes	No	Tumors or Growths	Yes	No
Chemotherapy	Yes	No	Heart Attack/Failure	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No
Chest Pains	Yes	No	Heart Murmur	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Pacemaker	Yes	No	Radiation Treatments	Yes	No	Yellow Jaundice	Yes	No
Congenital Heart Disorder	Yes	No	Heart Trouble/Disease	Yes	No	Recent Weight Loss	Yes	No	ADHD/ADD	Yes	No
Convulsions	Yes	No	Hypertension	Yes	No						

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

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 _____ DATE _____