

New Patient Registration Form

PATIENT INFORMATION

Last name:		First Name:		Middle Initial:	
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Other _____		Social Security #:		Birth Date: Sex: ☐ M ☐ F	
Street Address:		City:		State/Zip Code:	
Email address:					
Cell Phone:		Home Phone:		Work Phone: Ext:	
Primary Care Physician Name:		Physician Address:		Physician Phone:	
Employer Name:		Employer Address:		Occupation:	
Pharmacy Name:		Pharmacy Address:		Pharmacy Phone:	

I give **ProHEALTH Riverside Dental** consent to communicate with the following individual(s) about my healthcare Including but not limited to appointment details and treatment plans;

Name:	Relationship to Patient:
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PARENT/ GUARDIAN INFORMATION (IF PATIENT IS A MINOR)

☐ Not Applicable

Custodial Parent/ Guardian Name (s):	Phone Number:
Address:	
Custodial Parent/ Guardian Name (s):	Phone Number:
Address:	

CAREGIVER INFORMATION (IF APPLICABLE)

☐ Not Applicable

In the case that no parent/guardian can be reached, please allow the following named individual to consent to Dental Treatment for the above-named child in accordance with **ProHEALTH Dental** Policy:

1. Parent/Guardian must be present and consent for new Dental Treatment.
2. Caregiver may bring child in for pre-determined treatment discussed with parent and hygiene exam.
3. Unexpected treatment discovered when caregiver is present requires oral consent of the parent/guardian which office staff must obtain and record in chart.

Caregiver's Full Legal Name:	Date of Birth:
Address:	Phone Number:
Relationship to Child:	

Adult Health History Form

(Patient 18 and Over)

SKIP THIS PAGE FOR PEDIATRIC PATIENTS

Have you ever had any of the following? Please check those that apply:

- | | | | | | |
|--|---|--|--|---|---|
| ☐ ADHD | ☐ Cancer | ☐ Growths | ☐ Jaw Pain | ☐ Respiratory Problems | ☐ Tumors |
| ☐ AIDS/HIV | ☐ Codeine Allergy | ☐ Hay Fever | ☐ Kidney Disease | ☐ Rheumatism | ☐ Ulcers |
| ☐ Allergies: _____ | ☐ Diabetes | ☐ Head Injuries | ☐ Liver Disease | ☐ Sinus Problems | ☐ Venereal Disease |
| ☐ Anemia | ☐ Developmental Disorder | ☐ Headaches | ☐ Mental Disorders | ☐ Sleep Apnea | ☐ Other: _____ |
| ☐ Anxiety Disorder | ☐ Dizziness | ☐ Heart Disease | ☐ Nervous Disorders | ☐ Special Education | _____ |
| ☐ Arthritis | ☐ Epilepsy | ☐ Heart Murmur | ☐ Pacemaker | ☐ Stomach Problems | _____ |
| ☐ Artificial Joints | ☐ Excessive Bleeding | ☐ Hepatitis | ☐ Penicillin Allergy | ☐ Stroke | _____ |
| ☐ Asthma | ☐ Fainting | ☐ High Blood Pressure | ☐ Pregnancy | ☐ Snoring | |
| ☐ Autism | ☐ Facial Pain | ☐ Jaundice | Due Date: _____ | ☐ Tuberculosis | |
| ☐ Blood Disease | ☐ Glaucoma | ☐ Jaw Locking | ☐ Radiation Treatment | | |

Do you smoke?	☐ Yes ☐ No	If yes, how many per day:
Have you ever had any complications following dental treatment?	☐ Yes ☐ No	If yes, please explain:
Have you been admitted to a hospital or needed emergency care during the past two years?	☐ Yes ☐ No	If yes, please explain:
Are you now under the care of a physician?	☐ Yes ☐ No	If yes, please explain:
Do you have any health problems that need further clarification?	☐ Yes ☐ No	If yes, please explain:
Please list all medications and dosages you are currently taking:		

To the best of my knowledge, all the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Patient/Guardian Name (Print): _____

Date: _____

Patient/Guardian Name (Signature): _____

Date: _____

Adult Medical Questionnaire

(Patients 18 and Over)

SKIP THIS PAGE FOR PEDIATRIC PATIENTS

At **ProHEALTH Riverside Dental**, we care about your overall health and well-being. It's well-documented that certain oral health problems are related to many chronic diseases and can affect how you eat, sleep and live.

Please complete this questionnaire so we can help you be your healthiest you.

Name: _____ **Date:** _____

Please circle "yes" or "no" for each question:

Do you have high blood pressure or take blood pressure medication?	Yes	No
Do you have diabetes or pre-diabetes?	Yes	No
Have you ever experienced an irregular heart rhythm or been diagnosed with atrial fibrillation (aFib)?	Yes	No
Have you ever had a stroke, transient ischemic attack (TIA), or heart attack?	Yes	No
Do you often feel tired, fatigued, or sleepy during the daytime?	Yes	No
Have you ever been told you snore?	Yes	No
If yes, does your snoring bother anyone else?	Yes	No
Have you ever woken yourself up gasping or with heart racing?	Yes	No
Do you currently use a CPAP device while you sleep? If yes, do you sometimes skip a night or take it off while sleeping?	Yes	No

Discussed with patient: _____ Yes _____ No

Hygienist Name: Initials _____ Signature _____

E0008: Sleep Questionnaire form

E0006: Refer for Sleep Study/Physician

E0000: Positive Sleep Questionnaire if 2 or more answers of yes

***Please enter code in Dentrix at time of visit

Pediatric Health History Form

(Patients Under 18)

SKIP THIS PAGE FOR ADULT PATIENTS

Child's Name: _____ Nickname: _____ Date of Birth: _____

Address: _____ City: _____ State: _____

Zip: _____

Home Phone: _____ Cell Phone: _____ SS #: _____ Age: _____

Sex: ☐ Male ☐ Female Pronouns: _____

Parent #1: _____ Relationship to Patient: _____

Employer: _____ Work#: _____ Cell: _____

Email: _____ Date of Birth: _____ SS#: _____

Parent #2: _____ Relationship to Patient: _____

Employer: _____ Work#: _____ Cell: _____

Email: _____ Date of Birth: _____ SS#: _____

Have we seen other children in your family? _____

MEDICAL HISTORY

Child's Physician/ Pediatrician: _____ Phone: _____

☐ Yes ☐ No Is your child in good health? Date of last physical exam: _____

☐ Yes ☐ No Has your child ever had a health problem? _____

☐ Yes ☐ No Is your child allergic to anything? _____

☐ Yes ☐ No Are your child's immunizations/ vaccines up to date? If not, please explain: _____

☐ Yes ☐ No Has your child had any surgeries/ hospitalizations? If yes, please explain: _____

☐ Yes ☐ No Is your child currently taking any medications? Please give medications, dosage, and reason: _____

☐ Yes ☐ No Has your child ever had a blood transfusion

☐ Yes ☐ No Does your child smoke or use tobacco products?

☐ Yes ☐ No Has your child previously seen a dentist?

Date last seen: _____ Name of Dentist: _____

☐ Yes ☐ No Has your child ever received fluoride in any form?

☐ Yes ☐ No Does your child suck his/her thumb or fingers?

☐ Yes ☐ No Are your child's teeth brushed once or more a day?

☐ Yes ☐ No At what age did your child stop bottle/breast feeding? _____

Please check any of the following which your child has been treated for:

☐ Aids	☐ Cleft Lip/Palate	☐ Heart Disease	☐ Pregnant	☐ Spinal Bifida
☐ ADHD	☐ Congenital Birth Defects	☐ Heart Murmur	☐ Rheumatic Fever	☐ Syndrome
☐ Anemia	☐ Diabetes	☐ Hepatitis	☐ Seasonal Allergies	☐ Tonsils/Adenoid
☐ Asthma/Breathing	☐ Endocrine/Growth	☐ Kidney Disease	☐ Seizures	☐ Tuberculosis
☐ Autism	☐ Eyesight	☐ Latex Allergy	☐ Shunt	
☐ Blood Dyscrasias	☐ Food Allergies	☐ Liver/GI Disease	☐ Sickle Cell Disease	
☐ Cancer/Tumors	☐ Frequent Infections	☐ Mental Delays	☐ Snoring	
☐ Cerebral Palsy	☐ Headaches	☐ Personality/ Social	☐ Speech/Hearing	
☐ Other: _____				

____ Yes ____ No	Does your child snore?
____ Yes ____ No	Does your child wake up with headaches in the morning?
____ Yes ____ No	Does your child seem sleepy during the day?
____ Yes ____ No	Has your child ever woken gasping for air?
____ Yes ____ No	Has anyone in your family been diagnosed with sleep apnea? If yes, what treatment was received? _____

Is there anything else we should know about your child?

Signature of Legal Guardian: _____ Relationship to Patient: _____

Date: _____

RESPONSIBLE PARTY INFORMATION				
The following is for: ☐ Patient ☐ Person Responsible for Payment ☐ Relationship to Patient _____				
Name:		Sex: ☐ M ☐ F	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Other _____	
SS#:	Birth Date:	Home Phone:	Work Phone:	Cell Phone:
Street Address:		City/State/Zip:		
INSURANCE INFORMATION				
PRIMARY INSURANCE:				
Occupation:	Employer:	Employer Address:	Employer Phone:	
Name of Primary Insurance:				
Subscriber's Name:		Birth Date:	Group #:	ID #:
Patient's Relationship to Subscriber:	☐ Self ☐ Spouse ☐ Child ☐ Other: _____			
SECONDARY INSURANCE:				
Occupation:	Employer:	Employer Address:	Employer Phone:	
Name of Secondary Insurance:				
Subscriber's Name:		Birth Date:	Group #:	ID #:
Patient's Relationship to Subscriber:	☐ Self ☐ Spouse ☐ Child ☐ Other: _____			

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign all insurance benefits directly to **ProHEALTH Riverside Dental** that are otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits and authorize the use of this signature on all insurance submissions.

Patient/Guardian Name (Print):

Date:

Patient/Guardian Name (Signature):

Date:

Consent for Dental Treatment and Acknowledgement of Receipt of Information

State law requires our office to obtain your consent for your contemplated oral care and dental treatment. Please read this form carefully and ask about anything you do not understand. We will be pleased to further explain and discuss your concerns and questions.

I hereby authorize consent for oral and dental treatment that may include, but not limited to, the following: examination, radiographs (x-rays), diagnosis, dental prophylaxis (cleaning), fluoride treatment, restorations (i.e. fillings, pulpotomy, stainless steel crowns), anesthesia, oral surgery (extractions), interceptive orthodontic treatment and emergency treatment.

I understand that during any planned procedure, unforeseen conditions may arise that may necessitate treatment or procedures in addition to, or different from those originally discussed. In addition, although I am not advised that positive results are expected, the possibility and nature of complications cannot be accurately anticipated and, therefore, there can be no guarantee expressed or implied either as to the result of treatment.

Although their occurrence is not frequent, some risks and complications are known to be associated with dental or oral surgery procedures. These risks include, but are not limited to the following: nausea following anesthesia, numbness, infection, swelling, prolonged bleeding, discoloration, vomiting, allergic reactions, swallowing or aspiration of various materials (i.e. stainless-steel crowns), injury to the tongue, lips, cheeks, damage to possible loss of existing teeth and/or restorations (fillings), injury to nerves near the treatment site and fracture of a tooth root which may require additional surgery for its removal. I further understand and accept that complication may require additional medical, dental or surgical treatment and may require hospitalization.

Integrated Health Screening Consent

ProHEALTH Riverside Dental provides a convenient, noninvasive chairside screening for critical clinical vital sign data that may reveal an undiagnosed medical condition. While this is not a definitive diagnosis of a particular health complication - it may indicate the need for further evaluation.

Screening includes routine blood pressure, blood oxygenation, diagnostic heart rhythm monitor reading and oral cancer screening and head & neck examination.

Understanding this Form

I hereby state that I have read and understand this consent form, that I have been given the opportunity to ask questions that I might have and that all questions have been answered in a satisfactory manner. I understand that I have the right to be provided with answers to questions that may arise during the course of my treatment.

I further understand that I am free to withdraw my consent to treatment at any time, and that my consent will remain in effect until such time that I choose to withdraw it.

Patient/Guardian Name (Print):

Date:

Patient/Guardian Name (Signature):

Date:

Referral Information

Tell us how you learned about our practice.

Please choose one blue box and then select one of the choices within that box.

01 **Neighborhood:** **Select one:** Neighborhood • Saw Sign • Walk In

02 **Insurance Company:** _____
Company Name

03 **Family / Friend:** _____
Name of Family Member or Friend

04 **Online:** **Select one:** Internet Search • Social Media • Website

05 **Advertisement:** **Select one:** Flyer/Postcard • Magazine • Mailing • Newspaper
Outdoor/Community • Television

06 **Event:** _____
Event Name

07 **Dentist:** _____
Dentist Name

08 **Employee:** **Select one:** Our Company • CareMount • Catholic Health • Mt. Sinai
Optum • ProHEALTH • Riverside • WestMed

09 **Other:** _____
Description

99 **Doctor / Medical Office:** **Select one:** CareMount • Catholic Health • Mt. Sinai
Optum • ProHEALTH • Riverside • WestMed

Doctors Name

Financial Agreement

Our goal is to provide the highest quality of dental care possible as well as a positive patient experience. Please see our financial policy.

All accounts are due and payable at time of service.

If a procedure requires multiple appointments, payment may be paid with a minimum of two payments or based on the number of appointments to complete treatment.

Payment Options:

- Cash
- Check
- Visa / MasterCard / Discover / AMEX
- The Lending Club / Care Credit

Patients with Insurance: The patient/guarantor is responsible for the **estimated** non-covered portion, procedures and/or deductibles at the time of the service. Due to insurance policy changes and/or necessary changes in treatment plans, the insurance coverage may vary from the estimated treatment calculation. I acknowledge this is an estimate only and that I, not the insurance company, am ultimately responsible for payment in full for all services not covered for any reason by my insurance.

Parents not accompanying their child to an appointment must make **prior** arrangements for payment (cash, check or credit card authorization). **Parents accompanying their children** are financially responsible for payment.

There is a processing charge for **non-sufficient funds** or returned checks.

As instruments, chairs and personnel are reserved exclusively for your appointment, there may be a fee charged for changed or broken appointment with less than 24 hours in advance.

Patient/Guardian Name (Print):

Date:

Patient/Guardian Name (Signature):

Date:

Acknowledgement of Privacy Practices

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

- Provide and coordinate my treatment among many health care providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers for my health care services.
- Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office to obtain a current copy of the *Notice of Privacy 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 understand that 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/Guardian Name (Print):

Date:

Patient/Guardian Name (Signature):

Date: