ADULT VERSION
patients 18 and older

ProHEALTH Riverside Dental™
Put Your Health Where Your Mouth Is™

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:**

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 Riverside 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

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

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

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: _____

Annual Medical Questionnaire for Sleep Disorders

At ProHEALTH Riverside Dental, we care about your overall health and well-being. It is 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_____
Height_____ Weight_____ Age_____ Male / Female _____ Date_____

Have you been diagnosed with Sleep Apnea before and received treatment?	☐ YES	☐ NO
If you answered "YES" to the above question, please STOP and hand the questionnaire to a staff member.		

PATIENT RESPONSES		
STOP		
Do you **SNORE** loudly (louder than talking or loud enough to be heard through closed door)?	YES	NO
Do you often feel **TIRED**, fatigued, or sleepy in the daytime?	YES	NO
Has anyone **OBSERVED** you stop breathing during your sleep?	YES	NO
Do you have-or are you being treated for high blood **PRESSURE**?	YES	NO
TOTAL:		

BANG		
BMI higher than 35kg/m2?	YES	NO
AGE over 50 years old?	YES	NO
NECK circumference greater than 16 inches (40cm)?	YES	NO
GENDER: MALE?	YES	NO
TOTAL:		

High risk of OSA: Yes 5 – 8 **Intermediate risk of OSA: Yes 3 – 4** **Low risk of OSA: Yes 0 – 2**

For internal use only: **Discussed with patient:** YES NO Hygienist name _____Date: _____

Circle the code below based on findings and record in Dentrix at the time of visit:

E0008: Sleep questionnaire form administered **HYG initials _____**

E0000: Positive sleep questionnaire form (if two or more answers are YES) **HYG initials _____**

E0006: Refer for sleep consultation/ home test/physician **HYG initials _____**

Patient is in active treatment: YES NO **Patient is interested in consultation: YES NO**

If two or more "YES" answers, schedule complimentary sleep consultation at ProHEALTH Dental.

This form must be scanned into patient's Document center.

Responsible Party and Insurance Info

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 and Communications 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.

This constitutes your consent for ProHEALTH Riverside Dental to use automated technology, including emails and texts to contact you at the phone numbers and email address provided about ProHEALTH Riverside Dental services.

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*
065	**Renew Rep / Dentist:**		_____ *Name*
07	**Dentist:**		_____ *Dentist Name*
08	**Employee:**	***Select one:***	Our Company • CareMount • Catholic Health • Mt. Sinai Northwell • Optum • ProHEALTH • Riverside • WestMed • Other
09	**Other:**		_____ *Description*
99	**Doctor / Medical Office:**	***Select one:***	CareMount • Catholic Health • Mt. Sinai • Northwell Optum • ProHEALTH • Riverside • WestMed • Other _____ *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: