DAVID K. ANDREWS, D.D.S.

PATIENT REGISTRATION

Date: _____

Patient: _____

DOB: _____ Age: _____ (Circle:) Married/Single

Address: _____ City: _____State: _____ Zip: _____

SS#_____ Driver's License: _____Sex: M F

Email: _____Home# _____ Cell# _____

PATIENT'S EMPLOYER INFORMATION (Parent if minor)

Employer: _____

Address: _____ City: _____ State _____

Phone # _____

PRIMARY DENTAL INSURANCE

Carrier: _____Phone # _____

Insured: _____ Employer _____

Insured SS# _____ ID# _____ Group# _____

Insured's DOB _____ Relationship to patient: _____

SECONDARY DENTAL INSURANCE

Carrier: _____ Phone #_____

Insured: _____ Employer _____

Insured SS# _____ ID# _____ Group# _____

Insured's DOB _____Relationship to patient: _____

Are there any other family members who are patients in this office? If so, please list:

_____

Referred by: _____ Phone # _____

MEDICAL HISTORY

(Please circle where applicable)

AIDS	Dizziness	High Blood Pressure	Rheumatic Fever
Allergies (Seasonal)	Drug Addiction	HIV Positive	Rheumatism
Anemia	Emphysema	HPV (Human Papilloma Virus)	Scarlet Fever
Angina (Chest Pain)	Epilepsy	Jaundice	Seizures
Arthritis	Excessive Bleeding	Jaw Joint Pain	Sinus Problems
Artificial Heart Valve	Fainting	Kidney Disease	Sleep Apnea
Artificial Joints	Glaucoma	Liver Disease	Stomach Problems
Asthma	Heart Conditions	Low Blood Pressure	Stroke
Blood Disease	Heart Lesions (Congenital)	Mitral Valve Prolapse	Stomach Problems
Bruise Easily	Heart Murmur	Nervousness/Depression	Tuberculosis
Cancer	Heart Surgery	Pacemaker	Ulcers
Cervical Cancer	Hepatitis A	Pregnant	Venereal Disease
Chemotherapy	Hepatitis B	Radiation (head/neck)	Other
Diabetes	Hepatitis C	Respiratory Problems	

Are you allergic or have you reacted adversely to any of the following medications?

Aspirin	Percodan	Tetracycline	Valium	Other
Darvon	Latex	Codeine	Penicillin	_____
Nitrous Oxide	Local Anesthetic	Erythromycin	Sulfa	_____

What medications are you currently taking?

_____

_____

DATE: _____

What medications are you currently taking?

_____

_____

Do you smoke or chew tobacco? Yes/No How long? _____

Do you have sensitivity? Yes/No If so where? _____

Are you interested in whitening your smile? Yes/No

Are you interested in braces? Yes/No

If I could change my smile, I would _____

_____

_____

PARENT/GUARDIAN IN THE TREATMENT ROOM: Parents/Guardians are permitted to be with their child during the first cleaning or exam appointment; however, at each subsequent appointment, we ask that the parent/guardian retreat to the lobby area until their child's treatment has been completed. *Our intentions are to establish a rapport with your child, to give them our full attention, to gain their confidence and help them overcome apprehension.* Also, the doctor may be performing an invasive procedure, such as a filling, and minimal movement, conversation and distraction in and around the operative area are crucial for focus and optimal care of our patients. There may be circumstances that require a parent/guardian to be present. This will be done on a case-by-case basis. We thank you for your cooperation and support. _____ Parent/Guardian Initials

In case of emergency, contact: _____ Phone # _____

Your office has my permission to contact/discuss my appointments, account or treatment with:

Name_____ Phone # _____

PATIENT AGREEMENT AND RELEASE

I _____ *(Parent's Name if minor)* understand that all fees are due at the time of service. I agree to allow Dr. Andrews to file insurance claims on my behalf and I will pay all patient portions and co-pays estimated by his staff. I also understand anything not paid by my insurance is due in-full upon notice from Dr. Andrews or my insurance carrier. I agree to allow my insurance carrier to pay Dr. Andrews directly and not to me. If I fail to comply and my account goes to collection I agree to pay all legal and court cost involved.

Patient Signature *(Parent if child)* _____ **Date** _____

NOTICE OF PRIVACY PRACTICES

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information.

I have received and reviewed privacy practices from **Dr. David K. Andrews, D.D.S.** explaining how my health information is used and disclosed. I understand that Dr. Andrews may change his privacy practices without notice, at any time and a copy will be made available to me at my request. Such copies will also be posted in Dr. Andrews office and on his website.

I understand that I may request in writing that you allow "minimum necessary" restrictions on my health information, in order to carry out treatment, payment or healthcare operations. I also understand that my request has to be within reason.

Patient Signature *(Parent if child)* _____ **Date** _____

Consent:

I undersigned hereby authorize Dr. Andrews to perform any and all forms of treatment, medication and therapy deemed appropriate to care of the patient's dental needs. Also I understand the use of anesthetic agents embodies a certain risk. I have read, understand and agree to the above terms and conditions.

Patient Signature *(Parent if child)* _____ **Date** _____