Patient Registration

Hazen Smiles
HEALTHY SMILES FOR LIFE

Patient's Name:_____ Date of Birth:_____

Mailing Address:_____ Social Security #:_____

City/State/Zip:_____

Primary Phone #:_____ Secondary Phone #:_____

Employer:_____ Work Phone:_____

Emergency Contact: _____ Contact Phone #:_____

Person Responsible for Account: *If same as above, please check here: ◯

Name:_____ Date of Birth:_____

Mailing Address:_____ Social Security #:_____

City/State/Zip:_____ ___

City/State/Zip:_____ ___

Primary Phone #:_____ ___ Secondary Phone #:_____

Employer:_____ Work Phone:_____

****** Guarantor must be present for patients under the age of 18 ******

Patient Information:

Sex:
☐ Male ☐ Female

Marital Status:
☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Employment Status:
☐ Full Time ☐ Part Time ☐ Self Employed ☐ Retired ☐ Unemployed

Student:
☐ Full Time ☐ Part Time

Preferred Dentist: _____ Preferred Hygienist: _____

Preferred Pharmacy: _____

Please let us know how you heard about us! Referred by: _____

Primary Insurance Information: If insurance card is present, Do Not Complete

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other

Employer ID: _____ Carrier ID: _____

Insured Social Security #: _____ Insured Birth Date: _____

Employer: _____ Insurance Company: _____

Address: _____ Address: _____

_____ _____

Secondary Insurance? Be Sure to Let Us Know!

Medical History

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Patient's Name: _____ Date of Birth: _____

Height: _____ Weight: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is 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	
Have you ever been hospitalized or had a major operation?	◯ Yes	◯ No	
Have you ever had a serious head or neck injury?	◯ Yes	◯ No	If yes, please explain:
Do you have any artificial joints?	◯ Yes	◯ No	If yes, please explain:
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes	◯ No	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes	◯ No	
Are you on a special diet?	◯ Yes	◯ No	
Do you use tobacco?	◯ Yes	◯ No	If yes, please list type:
Do you use controlled substances?	◯ Yes	◯ No	If yes, list:
Are you taking any medication, pills or drugs?	◯ Yes	◯ No	If yes, list:
Are you required to take a pre-medication?	◯ Yes	◯ No	If yes, explain:
Are you ***currently*** taking steroids?	◯ Yes	◯ No	

Women: Are you: Pregnant/Trying to get pregnant? _____ Taking oral contraceptives? _____ Nursing?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Other, please list:

_____

Chest/Heart			**Infectious Disease**			**Joint**		
Chest pains/Heart Trouble	☐ Yes	☐ No	AIDS/HIV Positive	☐ Yes	☐ No	Arthritis/Gout	☐ Yes	☐ No
Congenital Heart	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Artificial Joints	☐ Yes	☐ No
Heart Attack	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No	Venereal Disease (STD)	☐ Yes	☐ No	Pain in Jaw Joints	☐ Yes	☐ No
Heart Pacemaker	☐ Yes	☐ No	Shingles	☐ Yes	☐ No	Rheumatism	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	MRSA	☐ Yes	☐ No	Swelling of Limbs	☐ Yes	☐ No
High Cholesterol	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No	**Blood**		
Irregular Heartbeat	☐ Yes	☐ No	Cold Sores	☐ Yes	☐ No	Anemia	☐ Yes	☐ No
Low Blood Pressure	☐ Yes	☐ No	**Head/Mental Health**			Blood Disease	☐ Yes	☐ No
Angina	☐ Yes	☐ No	Alzheimer's	☐ Yes	☐ No	Blood Transfusion	☐ Yes	☐ No
Artificial Heart Valve	☐ Yes	☐ No	Convulsions	☐ Yes	☐ No	Bruise Easily/Bleeding	☐ Yes	☐ No
Lungs/Respiratory			Drug Addiction	☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Epilepsy Seizures	☐ Yes	☐ No	Sickle Cell Disease	☐ Yes	☐ No
Breathing Problems	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No	**Other**		
Frequent Cough	☐ Yes	☐ No	Fainting/Dizziness	☐ Yes	☐ No	Cancer	☐ Yes	☐ No

Hay Fever	☐ Yes	☐ No	Nervous	☐ Yes	☐ No	Chemotherapy	☐ Yes	☐ No
Lung Disease	☐ Yes	☐ No	Stroke	☐ Yes	☐ No	Hypoglycemia	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Anaphylaxis	☐ Yes	☐ No	GERD	☐ Yes	☐ No
Easily Winded	☐ Yes	☐ No	Hives/Rash	☐ Yes	☐ No	Leukemia	☐ Yes	☐ No
Sleep Apnea	☐ Yes	☐ No				Liver Disease/Jaundice	☐ Yes	☐ No
Kidney			**Endocrine**			Radiation Treatment	☐ Yes	☐ No
Kidney Problems	☐ Yes	☐ No	Thyroid Disease	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Renal Dialysis	☐ Yes	☐ No	Parathyroid Disease	☐ Yes	☐ No	Tumors/Growth	☐ Yes	☐ No
						Diabetes	☐ Yes	☐ No

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

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Informed Consent for General Dental Procedures

You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

By consenting to the treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

Consent for anesthesia: In preparation for some treatment, anesthetics are needed. As a result of the injection or use of anesthesia, there may be swelling, jaw muscle tenderness or even a resultant numbness of the tongue, lips, teeth, jaw and or facial tissues that is usually temporary, however, in rare instances, such numbness may be permanent.

It is very important that you provide your dentist with accurate information before, during, and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

1. **Treatment to be Provided**
    a. I understand that during my course of treatment that the following care may be provided:
        i. Examinations, preventive services, restorations, crowns, bridges, root-canals, fillings, impressions, and any other general dentistry the Dr. deems necessary.
2. **Drugs and Medications**
    a. I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues; pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).
3. **Changes in Treatment Plan**
    a. I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary.
4. I give permission for the dental office to bill my dental insurance provider for the treatment provided, if applicable.

Patient Signature:_____ **Date:**_____

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FINANCIAL POLICY

1. Payment is due at the time services are rendered, unless prior financial arrangements have been made with the Office Manager.
2. Insured patients are expected to pay the estimated portion of treatment costs at the time of treatment, including any co-payment and deductible.
3. Out of state patients must pay in full at time of services regardless of insurance arrangement.
4. Non-participating providers: Should your insurance carrier not be contracted with Hazen Smiles. We will submit your insurance claim to your insurance company on your behalf. Payment for services, in full, is due at the time the services are rendered. Your insurance company should reimburse you per your benefits.
5. Overdue accounts are subject to service charges and if not taken care of in a timely manner, submission to a collection agency.
6. Fees for treatment are the obligation of the patient or person responsible for the account whether or not any insurance payment is collected.

It is not the responsibility of Hazen Smiles to track insurance benefits used and those which remain available to be used. The clinic staff will make their best effort to assist patients in tracking insurance benefits. However, any charges that exceed insurance benefits are the responsibility of the patient or person responsible for the account.

Patient Signature: _____ Date:_____

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HIPAA AUTHORIZATION

Patient Name:_____ DOB:_____

Please let us know how you would like to be contacted, mark all that apply:

☐ Text _____

☐ Phone _____

☐ E-Mail _____
E-Mail Address

I authorize the access, use, and/or disclosure of my information by Hazen Smiles, including its providers and clinical administrative staff members in relation to our patient/provider relationship, as described below.

The type and amount of information to be accessed, used and/or disclosed is as follows: (1) communications between myself and Hazen Smiles for treatment, payment and/or treatment operations via LightHouse 360's communications platform across digital, social media, texting, and/or other communication channels; and (2) transmissions of my patient information for treatment purposes only sent and/or received between Hazen Smiles and my other treatment providers (or other providers to whom I may be referred to); and/or (3) with a person of my designation who may call on my behalf to discuss financial/personal/medical/dental related information..

I understand that I have the right to revoke this authorization at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization.

I understand that Hazen Smiles may not condition, prohibit, or prevent my treatment on whether I sign this authorization.

I understand that, upon request, I will be given a copy of, or access to, this authorization form after it is signed.

Signature of Patient: _____

Name/Signature of Personal Representative: _____

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Restorative Functions Consent Form

You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

During our restorative process when placing dental fillings, we utilize an expanded functions dental assistant to place composite restorations in teeth following the dentist's removal of decayed tooth structure. Once restorations are in place, the dentist will check and adjust the bite and restorations. Restorative functions dental assistants attend advanced training specializing in placing composite fillings in teeth.

The restorative functions assistant is working with the doctor to complete my treatment.
I authorize a restorative functions dental assistant to place restorations in accordance with their license to perform restorative functions in the state of North Dakota.

Printed Patient Name_____

Patient Signature_____ Date: _____