KEVIN J POTTS D.D.S.

PATIENT REGISTRATION

Welcome! We want to provide you with the best possible care. Please assist us by thoroughly answering all the questions below. All information is completely confidential.

NAME ______________________ Birth date ________ Age ____ SSN ____________

Preferred name ______________________

Street ______________________ Phone# ______________________

City ______________________ Cell # ______________________

State ____________ Zip ____________ E-mail ______________________

Employer ______________________

Insurance ______________________

Insurance I.D. No. ______________________

SPOUSE NAME

(or parent/guardian if above is a child) ______________________ Birth date ________ Age ____ SSN ____________

Street ______________________ Phone# ______________________

City ______________________ Cell # ______________________

State ____________ Zip ____________ E-mail ______________________

Employer ______________________

Insurance ______________________

Insurance I.D. No. ______________________

In case of emergency, who should be notified? ______________________

Phone ______________________ Relation ______________________

BILLING INFORMATION

Person responsible for account ______________________ Relationship to patient ______________________

Address ______________________ City ____________ State ________ Zip ________

Phone ______________________ E-mail ______________________

Who may we thank for referring you? ______________________

Signature ______________________ Date ____________

MEDICAL HISTORY

Patient name ______________________________ Preferred name ______________

Name of Physician(s)/and their specialty ______________________________

Are you presently being treated for any illnesses or health issues ______________________________

Have you been hospitalized for any serious illnesses, operations or injuries in the last 3 years?

____

Are you aware of a change in your health in the last 24 hours (i.e. fever, chills, cough, diarrhea) □ Yes □ No

Describe any current medical treatment, impending surgery, genetic/developmental delay, or other treatment that may possibly affect your dental treatment ______________________________

DO YOU HAVE OR HAVE YOU HAD AN ALLERGIC REACTION TO:

- □ aspirin, ibuprofen, acetaminophen, codeine
- □ penicillin
- □ erythromycin
- □ tetracycline
- □ sulfa
- □ local anesthetic
- □ fluoride
- □ metals (nickel, gold, silver ________)
- □ latex
- □ other ______________

	YES	NO
Do you wear contact lenses?	□	□
Women only:		
Are you pregnant or could be pregnant?	□	□
Are you taking oral contraceptives?	□	□
Are you nursing?	□	□
Are you taking hormone replacements?	□	□
DO YOU HAVE OR HAVE YOU EVER HAD:		
Heart problems/condition	□	□
History of infective endocarditis	□	□
Repaired congenital heart defect	□	□
Artificial heart valve	□	□
Pacemaker or implantable defibrillator	□	□
Artificial prosthesis (hips, shoulders or knees)	□	□
High/low blood pressure	□	□
Tumor (abnormal growth)	□	□

DO YOU HAVE OR HAVE YOU EVER HAD:	YES	NO
Cancer (type(s) ______________)	□	□
Chemotherapy/immunosuppressive	□	□
Radiation therapy	□	□
Stroke	□	□
Anemia or other blood disorders	□	□
Prolonged bleeding due to slight cut (INR>3.5)	□	□
Respiratory disorders (emphysema, COPD)	□	□
Asthma	□	□
Sleep apnea/snoring	□	□
Kidney disease	□	□
Liver disease/Jaundice	□	□
Thyroid, parathyroid disease	□	□
High cholesterol	□	□
Diabetes (HbA1c= _____)	□	□
Stomach or duodenal ulcer	□	□
GI disorders (i.e. celiac disease, acid reflux)	□	□
Osteoporosis/osteopenia	□	□
Taken bisphosphonates (last taken: ______)	□	□
Glaucoma	□	□
Autoimmune disorder (i.e. rheumatoid arthritis, lupus)	□	□
Osteoarthritis	□	□
Epilepsy/convulsions (seizures)	□	□
Neurological disorders (ADD/ADH, prions)	□	□
Cold sores/fever blister	□	□
Hay fever/seasonal allergies	□	□
STI/STD	□	□
HIV/AIDS	□	□
Hepatitis (type ____)	□	□
Habitual illicit drug use	□	□
Smoker, use smokeless tobacco	□	□

Please list your current list of prescribed or over-the-counter medications and/or supplements you are currently taking:

______________ ______________ ______________ ______________

______________ ______________ ______________ ______________

______________ ______________ ______________ ______________

______________ ______________ ______________ ______________

I ATTEST THAT THE INFORMATION ABOVE IS ACCURATE AND TRUE TO THE BEST OF MY KNOWLEDGE:

Patient name ______________ Patient's signature ______________ Date ________

Provider name ______________ Provider signature ______________ Date ________

KEVIN J POTTS DDS

DENTAL HISTORY

Name____________ Nickname____________ Age______
Referred by____________ How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Previous Dentist____________ How long have you been a patient?______ Months/Years
Date of most recent dental exam ____/____/____ Date of most recent x-rays ____/____/____
Date of most recent treatment (other than a cleaning) ____/____/____
I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? ____________

PLEASE ANSWER YES OR NO TO THE FOLLOWING: **YES** **NO**

PERSONAL HISTORY

		YES	NO
1.	Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [ ]	☐	☐
2.	Have you had an unfavorable dental experience?	☐	☐
3.	Have you ever had complications from past dental treatment?	☐	☐
4.	Have you ever had trouble getting numb or had any reactions to local anesthetic?	☐	☐
5.	Did you ever have braces, orthodontic treatment or had your bite adjusted?	☐	☐
6.	Have you had any teeth removed?	☐	☐

GUM AND BONE

		YES	NO
7.	Do your gums bleed or are they painful when brushing or flossing?	☐	☐
8.	Have you ever been treated for gum disease or been told you have lost bone around your teeth?	☐	☐
9.	Have you ever noticed an unpleasant taste or odor in your mouth?	☐	☐
10.	Is there anyone with a history of periodontal disease in your family?	☐	☐
11.	Have you ever experienced gum recession?	☐	☐
12.	Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?	☐	☐
13.	Have you experienced a burning sensation in your mouth?	☐	☐

TOOTH STRUCTURE

		YES	NO
14.	Have you had any cavities within the past 3 years?	☐	☐
15.	Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?	☐	☐
16.	Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?	☐	☐
17.	Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth?	☐	☐
18.	Do you have grooves or notches on your teeth near the gum line?	☐	☐
19.	Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?	☐	☐
20.	Do you frequently get food caught between any teeth?	☐	☐

BITE AND JAW JOINT

		YES	NO
21.	Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	☐	☐
22.	Do you feel like your lower jaw is being pushed back when you bite your teeth together?	☐	☐
23.	Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?	☐	☐
24.	Have your teeth changed in the last 5 years, become shorter, thinner or worn?	☐	☐
25.	Are your teeth crowding or developing spaces?	☐	☐
26.	Do you have more than one bite and squeeze to make your teeth fit together?	☐	☐
27.	Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	☐	☐
28.	Do you clench your teeth in the daytime or make them sore?	☐	☐
29.	Do you have any problems with sleep or wake up with an awareness of your teeth?	☐	☐
30.	Do you wear or have you ever worn a bite appliance?	☐	☐

SMILE CHARACTERISTICS

		YES	NO
31.	Is there anything about the appearance of your teeth that you would like to change?	☐	☐
32.	Have you ever whitened (bleached) your teeth?	☐	☐
33.	Have you felt uncomfortable or self conscious about the appearance of your teeth?	☐	☐
34	Have you been disappointed with the appearance of previous dental work?	☐	☐

Patient's Signature ____________ Date______

Doctor's Signature ____________ Date ______

CONSENT FOR DENTAL PROCEDURES

I, ______________________________ hereby authorize to perform upon myself, child or legal ward the following dental treatment: Radiologic; (X-Rays), Preventive (Cleaning, Fluoride & Sealants), Operative (Fillings & Crowns), Surgical (Extractions & Surgery), Orthodontic, Prosthetic (Replacement of Missing Teeth), Behavioral, Restraining (For Safety) or other dental procedures including local anesthesia (Numbness) inhalation sedation (Laughing Gas) and/or conscious sedation (for apprehension or disruptive behavior), impressions, intraoral pictures, and extra oral pictures. The nature and purpose of the treatment and the procedures have been explained to me in general terms. Alternate procedures or methods of treatment, if any, have also been explained to me; as well as, their advantages and disadvantages, the risks (listed below) and probable effectiveness of each; as well as the prognosis of the treatment provided.

1. Nausea & Vomiting
2. Cheek and Lip Biting After Numbness
3. Post-Operative Discomfort and Swelling
4. Prolonged Bleeding That May Require Additional Treatment
5. Infection
6. Injury To Adjacent Teeth and Fillings
7. Fracturing of Root or Bone
8. Injury to the Nerve Underlying the Teeth Resulting in Numbness or Tingling of the Lip, Chin, Gums, Cheek, Teeth and or Tongue
9. Swallowing or Aspiration of Tooth, Crown Form, Cotton or Other Dental Materials
10. Risk of Heart Infection (Bacterial Endocarditis) For Children With Heart Disease
11. Anesthesia Risks- Paresthesia (Permanent Numbness)
12. Allergic Reactions
13. Other

______________________________	______________________________
Patient Name (Print)	Parent/Legal Guardian (Print)
______________________________	______________________________
Signature	Date
______________________________	______________________________
Witness	Date

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISGLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY,

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. If you sign a Consent Form, we may use and disclose your medical records only for each of the following purposes: treatment, payment and healthcare operations.

- Treatment means providing, coordinating, or managing healthcare and related services by one or more healthcare providers. An example of this would include teeth cleaning services.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Healthcare operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information. We may, without prior consent, use or disclose protected health information to carry out treatment, payment, or healthcare operations in the following circumstances:

- In emergency treatment situations, if we attempt to obtain such consent as soon as reasonably practicable after the delivery of such treatment;
- If we are required by law to treat you, and we attempt to obtain such consent but are unable to contain such consent; or
- If we attempt to obtain your consent, but unable to do so, due to substantial barriers to communicating with you, and we determine that, in our professional judgement, your consent to receive treatment is clearly inferred from the circumstances.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Office:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonably requests to receive confidential communication of protected health information from us by alternative means or at alternative locations
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and Privacy Practices with respect to protected health information. This notice is effective as of October 11, 2011 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new Notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised of Notice of Privacy Practices from this office. You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this Notice or the policies and procedures of our office. We will not retaliate against your for filing a complaint.

◯ I do NOT authorize any information to be discussed with any family members or friends.

◯ I authorize information about treatment or appointments to be discussed with the following person(s):

____

I have read and understand the above information.

SIGNATURE OF PATIENT ______________________ DATE ____________

SIGNATURE OF PARENT OR GUARDIAN (if applicable)______________ DATE____________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

I, ______________________________, have received a copy of this office's Notice of Privacy Practices.

____
Please Print Name

____
Signature

____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communications barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please Specify)

____

____

____

Financial Guidelines

We are committed to providing you with the best possible dental care. It is our goal that you understand your treatment needs, as well as your financial responsibility before treatment begins. We strive to accurately predict the cost of your dental care and work with your budget. If you have insurance, we want to help you receive your maximum allowance benefit. To provide you the best possible experience, we ask for your assistance.

- We will file the necessary paperwork to bill your insurance company for your dental treatment. We ask that you please provide us with accurate information at the time of your appointment.
- We request payment in full at the time of service, if you do not have insurance coverage unless other financial arrangements have been made in advance.
- We ask that the parent bringing a child to the practice be prepared with co-payment or full payment at the time of treatment regardless of custody agreements.
- We ask that you pay by cash, check or credit card for all estimated co-payments at the time of treatment. We are happy to help you secure financing from our available options.
- We reserve the right to bill for any missed or short notice (within 24 hours) canceled appointments. The amount of the charge will depend on the length of the appointment. Minimum charge would be $75.00 and it would need to be paid prior to any further appointments being scheduled.

Agreement of Financial Guidelines

I request and authorize ***Dr. Potts*** to provide me with dental care. I understand that I am personally responsible for the charges for the services I receive.

I agree to make full payment for services I receive. I understand that regardless of dental insurance benefits, any treatment I receive is my financial responsibility.

I hereby authorize ***Dr. Potts*** at his discretion, to bill my insurance carrier and any other persons or parties who may be liable for payment of these services. I also authorize my insurance carrier to make payment directly to ***Dr. Potts.***

Your signature below will acknowledge that you have read and agree to our financial guidelines.

Signature____Date______________