AESTHETIC DENTISTRY of Georgetown

BEAUTY • HEALTH • CONFIDENCE

GUEST REGISTRATION

PERSONAL INFORMATION

Name_____ Preferred Name_____
Address_____
City/State/Zip_____
Home Phone _____ Mobile Phone _____
EMAIL ADDRESS _____
Preferred Contact Method/s: _____Text _____ Email _____Phone
Social Security #_____DOB_____
Marital Status (Circle One) S M Gender (Circle One) M F
Employer_____ Work Phone _____ Ext._____

DENTAL POLICY HOLDER INFORMATION

Subscriber Name _____ Subscriber Employer_____
Social Security #_____ DOB _____
Dental Insurance Co _____Insurance Phone #_____
Member ID#_____ Group Number_____

WHOM MAY WE THANK FOR REFERRING YOU?

Family Member/Friend _____ Doctor _____
Internet/Google _____ Social Media _____
Mailer/Magazine _____ Drive-By _____
Other-Specify _____

EMERGENCY CONTACT

Name _____
Home Phone _____Mobile Phone_____
Work Phone _____ Ext _____

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MEDICAL HISTORY

Do you have any of the following?

Yes/No		Yes/No		Yes/No	
___ ___	Any heart problems	___ ___	Hepatitis A (infectious)	___ ___	Glaucoma
___ ___	Abnormal blood pressure	___ ___	Hepatitis B (serum)	___ ___	AIDS/HIV
___ ___	Stroke	___ ___	Jaundice	___ ___	Blood Transfusion
___ ___	Circulatory problems	___ ___	Malignancies	___ ___	Sinus Problems
___ ___	Excessive bleeding	___ ___	Rheumatic fever	___ ___	Botox Use
___ ___	Anemia	___ ___	Unfavorable reaction to dental anesthetic	___ ___	Do you use tobacco How often_____
___ ___	Arthritis				
___ ___	Respiratory problems	___ ___	Fainting tendency	___ ___	Are you a nursing mother
___ ___	Epilepsy	___ ___	Tuberculosis	___ ___	Are you pregnant
___ ___	Diabetes	___ ___	Thyroid disease	Due Date_____	

Do you have a history of rheumatic fever, heart murmur, artificial valve or joint replacement which now requires premedication? (circle which one) comments: _____

Are you allergic to any drugs? _____Please list_____

Are you currently taking any medications? _____Please list_____

_____

Have you taken medication for bone density or Osteoporosis? _____Please list_____

Are there any other medical conditions of which I should be aware? _____

Are you presently under the care of a physician? Y or N If so, for what?_____

Have you ever been hospitalized? _____What for? _____

_____

Do you have a family history of heart disease, diabetes, or periodontal disease? _____

Are you waking up frequently during the night? _____ Do you wake up with headaches? _____

Have you ever been treated for snoring or sleep apnea? _____ Have you had a sleep study? _____

Date of study _____ Have you ever used a CPAP? _____ If so, was it successful? _____

DENTAL HISTORY

Are you currently experiencing a toothache or any other pain in your head or neck? If so, please describe: _____

_____

Date of your last dental treatment or cleaning? _____ Date of last dental X-rays? _____What type? _____

Would you change anything about the appearance of your smile? _____

Do you have any of the following:

Yes/No		Yes/No		Yes/No	
___ ___	Periodontal disease	___ ___	Halitosis (Bad breath)	___ ___	Bruxism (Grinding teeth)
___ ___	Abscesses	___ ___	Sensitivities (Hot, Cold Sweets, Biting)	___ ___	Clicking/Popping TMJ
___ ___	Sores (Ulcers)			___ ___	Pain/fatigue in jaw joint
___ ___	Cold sores/Fever blisters	___ ___	Headaches	___ ___	Dizziness

Are there any other conditions or experiences of which I should be made aware of? _____

_____ _____

Guest Signature Date

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NOTICE OF PRIVACY PRACTICES

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that the doctor and all staff members continually undergo training so that we may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule".

The Department of Health and Human Services has established a "Privacy Rule" to help ensure that your personal health information is protected from unnecessary distribution. The Privacy rule has also been created to provide a standard for certain health care providers to obtain their patient's consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

We strive to achieve the very highest standards of ethics, integrity, and quality in performing services for our patients. As our patient, we want you to know that we respect the privacy of your personal dental records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. None of your private information will be released to anyone but you without your expressed written consent.

It is our policy to properly determine the appropriate use of PHI in accordance with the governmental rules, laws, and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As a part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI. We also want you to know that we support your full access to your personal dental records. Other businesses that we deal with may have indirect treatment relationships with you (such as laboratories that only interact with doctors and not patients). In cases such as these, we may have to disclose some personal health information for purposes of treatment, health care operations or payment. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information. Should you refuse to disclose your personal health information to us, we have the right to refuse to treat you under this law. Should you disclose your information to us but refuse to allow us to disclose it to your insurance company; you will be responsible for the full balance on your account at the time of service, instead of the customary 30-day grace period that we allow for 3rd parties to pay.