Account #:_________ Patient Name:________________________________

PATIENT REGISTRATION

First Name: ________________________________ Last Name: __________________________ Middle Initial: ____

Preferred Name: ______________________ Patient is: ( ) Policy Holder
( ) Responsible Party

Responsible Party (parent/guardian if minor)

First Name: __________________________ Last Name: ____________________________ Middle Initial: ____

Address: ____ Address 2:__________________________________

City, State, Zip: ____Home Phone: _________ _______________________

Name of Employer: ___________________ Work Phone: ___________________ Ext: _________ Cellular: ___________________

Birth Date: ________________ Soc. Sec. _______________________ Driver Lic: _____________________

( ) Responsible Party is also a Policy Holder for Patient

Patient Information

Address: ____ Address: ________________________________

City: _________________________________ State/Zip: ________________________ Home Phone: _____________________

Name of Employer:_______________________ Work Phone: __________________ Ext: ___________ Cellular: _____________

Sex: ( ) Male ( ) Female Marital Status: ( ) Married ( ) Single ( ) Divorced ( ) Separated ( ) Widowed

Birth Date: ________________ Age: ________ Soc. Sec. ______________________ Drivers Lic: _______________________

E-mail: ____ ( ) I would like to receive correspondences via e-mail.

Employment Status: ( ) Full Time ( ) Part Time ( ) Retired
Student Status: ( ) Full Time ( ) Part Time

Additional Comments:

Employer ID: ____________________

Carrier ID: ______________________

Pref. Dentist: ______________________

Pref. Pharmacy: ____________________

Account #:_________ Patient Name:_______________________________

In order to maximize your insurance benefits to the fullest, please complete the following if card not provided:

Primary Insurance Information

Name of Insured: ______________________________ Relationship to Insured: ( ) Self ( ) Spouse ( ) Child ( ) Other

Insured Soc. Sec. ______________________________ Insured Birth Date: _________________________

Employer: __________________________________ Insurance Company: ____________________________ Group #: ________

Address: ______________________________ Address: ____________________________

City, State, Zip: __________________________ City, State, Zip: ________________________

Secondary Insurance Information

Name of Insured: ____________________________ Relationship to Insured: ( ) Self ( ) Spouse ( ) Child ( ) Other

Insured Soc. Sec: ____________________________ Insured Birth Date: ____________________

Employer: _________________________________ Insurance Company: ____________________________ Group #: ________

Address: _______________________________ Address: _______________________

City, State, Zip: ____________________________ City, State, Zip: __________________

Emergency Contact

Name: ______________________________________ Home/Cell Phone: ____________________________

Relationship: __________________________________ Work Phone: ____________________________

How did you hear about our office?

( ) www.purezendentistry.com ( ) Google ( ) Yelp ( ) Facebook ( ) ZocDoc ( ) Amazon Local ( ) Living Social

( ) Doctor's Office:____________________ ( ) Provider:________________________ ( ) Friend/Relative:_________________

( ) Other Source:_____________________ ( ) Not Referred

DENTAL HISTORY

Date of Last Dental Visit: ______________________

1. How often you brush your teeth? _________________
2. Do your gums bleed while brushing or flossing? ( ) Yes ( ) No
3. Are you currently experiencing any pain? ( ) Yes ( ) No
4. Are your teeth sensitive to hot or cold? ( ) Yes ( ) No
5. Are your teeth sensitive to sweet or sour? ( ) Yes ( ) No
6. Do you wear dentures or partials? ( ) Yes ( ) No
7. How would you rate your smile? ( ) 1 ( ) 2 ( ) 3 ( ) 4 ( ) 5 ( ) 6 ( ) 7 ( ) 8 ( ) 9 ( ) 10
8. Is anything you want to change about your smile? ( ) Yes ( ) No If yes, please explain: ___________________

Account #:_________ Patient Name:_______________________________

MEDICAL HISTORY

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.

Physician Name: ____________________________ Office Phone Number: (______) ________________

Are you under physician's care now?	( ) Yes	( ) No	If yes, please explain: ______________________
Have you ever been hospitalized or had a major operation?	( ) Yes	( ) No	If yes, please explain: ______________________
Have you ever had a serious head or neck injury?	( ) Yes	( ) No	If yes, please explain: ______________________
Are you taking any medications, pills, or drugs?	( ) Yes	( ) No	If yes, please explain: ______________________
Do you take, or have you taken Phen-Fen or Redux?	( ) Yes	( ) No	______________________
Are you on a special diet?	( ) Yes	( ) No	______________________
Do you use tobacco?	( ) Yes	( ) No	______________________
Do you use controlled substances?	( ) Yes	( ) No	______________________

Women:
( ) Pregnant/Trying to get pregnant? ( ) Nursing? ( ) Taking oral contraceptives?

Are you allergic to any of the following?

( ) Aspirin ( ) Penicillin ( ) Codeine ( ) Acrylic ( ) Metal ( ) Latex ( ) Local Anesthetics

( ) Other: Please explain: ____

Are you taking any of blood thinner medications?
If yes, please explain: ____

Do you have, or have you had, any of the following?

( ) AIDS/HIV Positive	( ) Cortisone Medicine	( ) Hemophilia	( ) Renal Disease
( ) Alzheimer's Disease	( ) Diabetes	( ) Hepatitis A	( ) Rheumatic Fever
( ) Anaphylaxis	( ) Drug Addiction	( ) Hepatitis B or C	( ) Rheumatism
( ) Anemia	( ) Easily Winded	( ) Herpes	( ) Scarlett Fever
( ) Angina	( ) Emphysema	( ) High Blood Pressure	( ) Shingles
( ) Arthritis/Gout	( ) Epilepsy/Seizures	( ) Hives or Rash	( ) Sickle Cell Disease
( ) Artificial Heart Valve	( ) Excessive Bleeding	( ) Hypoglycemia	( ) Sinus Trouble
( ) Artificial Joint	( ) Excessive Thirst	( ) Irregular Heartbeat	( ) Spina Bifida
( ) Asthma	( ) Fainting Spell/Dizziness	( ) Kidney Problems	( ) Stomach/Intestinal Disease
( ) Blood Disease	( ) Frequent Cough	( ) Leukemia	( ) Stroke
( ) Blood Transfusion	( ) Frequent Diarrhea	( ) Liver Disease	( ) Swelling of Limbs
( ) Breathing Problems	( ) Frequent Headaches	( ) Low Blood Pressure	( ) Thyroid Disease
( ) Bruise Easily	( ) Genital Herpes	( ) Lung Disease	( ) Tonsillitis
( ) Cancer	( ) Glaucoma	( ) Mitral Valve Prolapse	( ) Tuberculosis
( ) Chemotherapy	( ) Hay Fever	( ) Pain in Jaw Joints	( ) Tumors or Growths
( ) Chest Pains	( ) Heart Attack/Failure	( ) Parathyroid Disease	( ) Ulcers
( ) Cold Sores/Fever Blisters	( ) Heart Murmur	( ) Psychiatric Care	( ) Venereal Disease
( ) Congenital Heart Disorder	( ) Heart Pace Maker	( ) Radiation Treatments	( ) Yellow Jaundice
( ) Convulsions	( ) Heart Trouble/Disease	( ) Recent Weight Loss	

Have you ever had any serious illness not listed above? ( ) Yes ( ) No
If yes, please explain:____________________________

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 (Legal Guardian, if Minor) Date

______________________________________ ________________
Doctor's Signature Date

Account #:_________ Patient Name:______________________________

NOTICE OF PRIVACY ACTS

THIS TREATMENT DESCRIBES HOW MEDICAL INFROMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This practice is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment
We may disclose your health care information to other health care professionals within our practice for the purpose of treatment, payment or health care operations.

Payment
We may disclose your health care information to your insurance provider for the purpose of payment or health care operations.

Worker's Compensation
We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies
We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care, about your medical condition or in the event of an emergency or of your death.

Public Health
As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings
We may disclose your health information in the course of any administrative or judicial proceedings.

Law Enforcement
We may disclose your health information to a law enforcement official for the purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons
We may disclose your health information to coroners or medical examiners.

Organ Donation
We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research
We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety
It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies
We may disclose your health information for military, national security, prisoner and government benefits and purposes.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that this practice is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method of communication or delivery, upon your request.
- You have the right to inspect and request a copy of your health information.
- You have a right to request that this practice amend your protected health information. Please be advised, however, that this practice is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by this practice.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices
This practice reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, this practice is required by law to comply with this Notice.

This practice is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice, or if you want more information about your privacy rights, please contact our Privacy Officer by calling this office.

Complaints
Complaints about your privacy rights, or how this practice has handled your health information should be directed to our Privacy Officer by calling this office.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights 200
Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of _____/_____/_____.

Account #:_________ Patient Name:______________________________

ACNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this Acknowledgement

I have had full opportunity to read, understand the contents, and I have received a copy of this office's Notice of Privacy Practices. I understand that by signing this form, I am giving my consent for use and disclosure of my protected health information to carry out all payment activities and health care operations.

Patient's name ______________________________ Date ____________________

Signature _________________________________
(Parent/Guardian if minor)

AUTHORIZATION FOR COMMUNICATION

I authorize Pure Zen Dentistry to release the following information about my health care (please check all that apply):

□ Any and all information

□ Information necessary to schedule, confirm, cancel, or reschedule appointments

□ Information about prescriptions

□ Information about my bills or account

□ I grant permission to this individual to bring my child to his/her appointments

This authorization applies to the following individual(s)

Name: Relationship to the Patient:

_________________________________ _________________________________

_________________________________ _________________________________

□ I choose not to authorize any individuals at this time

I understand that this authorization is valid until revoked by the patient, or the patient's parent/guardian.