COMMUNITY DENTAL CLINIC
REGISTRATION FORM
(Please Print In English)

PATIENT INFORMATION

Patient's Legal Name:	Preferred First Name:	Maiden Name:

Marital status (circle one) Single / Mar / Div / Sep / Wid	Birth date: / /	Age:	Sex: ❑ M ❑ F	Social Security #:

Street address:	Primary Phone # (Where appointments are confirmed): ( )

City:	State:	Zip Code:	Alternate phone no: ( )

Employer:

Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan
❑ Family ❑ Friend	❑ Hospital / ER	❑ Urgent/Convenient Care

Other family members seen here:

PARENT/GUARDIAN INFORMATION (ONLY COMPLETE IF PATIENT IS UNDER 18)

Name:	Birth date: / /	Home phone no.: ( )
Address (if different):		Cell phone no: ( )

Relationship to Patient:	❑ Mother ❑ Father ❑ Guardian

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Phone no.: ( )

CANCELLATION / NO SHOW POLICY

Due to extreme demand for dental services, Community Dental Clinic appointments are booked several weeks in advance. When making an appointment, time and space are reserved especially for you. Instruments and supplies specific for your appointment needs, are sterilized and set-up in the treatment area. When you fail to keep your appointment, all these instruments must be re-sterilized and put away, thus resulting in wasted materials and money and increased waiting time to schedule future appointments. The time reserved for you cannot be used by anyone else without advance notice.

In order to better serve our patients, we ask for at least a 24 hour notice if you are unable to keep your appointment. Non-compliance or abuse of our cancellation policy will result in dismissal of patient from our office. We confirm all our appointments prior to the date of appointment by calling the phone numbers listed above. **Failure to confirm appointments by 12:00 pm of the prior business day will result in loss of appointments and possible dismissal of patient from our office**.

Tardiness is not tolerated in this office! If you are late for your appointment, you may not be seen or rescheduled. Chronic tardiness will result in dismissal of patient!

Sign and date showing you have read and understand our Cancellation / No Show Policy.

*****PLEASE NOTE: ANY PATIENT UNDER 18 YRS OF AGE MUST BE ACCOMPANIED BY LEGAL GUARDIAN OR AUTHORIZED ADULT (CONSENT FORM MUST BE ON FILE) DURING ENTIRE APPOINTMENT TIME.**

Patient/Guardian signature	***Date***

MEDICAL HISTORY

Patient Name_____ Birth Date_____ Height_____ Weight_____

Primary Physician's Name & Phone Number_____

***Are you currently taking any type of Blood Thinners?** YES_____ NO_____

- Common Blood Thinners Include: Aspirin, Plavix, Coumadin, or Warfarin

*Have you ever been hospitalized or had a major operation? YES_____ NO_____
If yes, please explain_____

***Are you taking any medications, pills, supplements, antibiotics, or drugs?** YES_____ NO_____
Please list medications_____

_____

_____

*Have you ever been told not to take Ibuprofen or Acetamenophen (Tylenol)? YES_____ NO_____

*Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? YES_____ NO_____

*Do you use tobacco products? YES_____ NO_____
Circle all that apply: Cigarettes E-Cigs / Juul Pods Smokeless Tobacco / Chewing Tobacco

*Do you drink alcohol? YES_____ NO_____ How many/ often?_____

*Do you use controlled substances, have a pain management plan or use a pain pump? YES_____ NO_____

*Do you or have you ever abused the following substances? YES_____ NO_____
Circle all that apply: Narcotics/ Opioids Methamphetamines Alcohol Other:_____

*Are you currently in a substance abuse treatment program? YES_____ NO_____ Where?_____

WOMEN:
Are you pregnant Y / N *Trying to get pregnant*? Y / N *Taking oral contraceptives*? Y / N *Nursing*? Y / N

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs

☐ Other:_____

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

AIDS/HIV Positive	YES NO	Congenital Heart Disorder	YES NO	High Blood Pressure	YES NO	Rheumatic Fever	YES NO
Alzheimer's Disease	YES NO	Cortisone Medicine	YES NO	High Cholesterol	YES NO	Rheumatism	YES NO
Anaphylaxis	YES NO	Diabetes	YES NO	Hives or Rash	YES NO	Scarlet Fever	YES NO
Anemia	YES NO	Drug Addiction	YES NO	Hypoglycemia	YES NO	Shingles	YES NO
Angina/Chest Pains	YES NO	Easily Winded	YES NO	Irregular Heartbeat	YES NO	Sickle Cell Disease	YES NO
Arthritis/Gout	YES NO	Emphysema	YES NO	Kidney Problems	YES NO	Sinus Trouble	YES NO
Artificial Heart Valve	YES NO	Epilepsy or Seizures	YES NO	Leukemia	YES NO	Spina Bifida	YES NO
		Excessive Bleeding	YES NO	Liver Disease	YES NO	Stomach/Intestinal	YES NO
Artificial Joint	YES NO	Excessive Thirst	YES NO	Low Blood Pressure	YES NO	Disease	
WHEN?_____		Fainting Spells/Dizziness	YES NO	Lung Disease	YES NO	Stomach Ulcers	YES NO
		Frequent Cough	YES NO	Mitral Valve Prolapse	YES NO	Stroke	YES NO
Asthma	YES NO	Frequent Headaches	YES NO	Osteoporosis	YES NO	Swelling of Limbs	YES NO
Blood Disease	YES NO	Heart Attack/Failure	YES NO	Pacemaker	YES NO	Thyroid Disease	YES NO
Blood Transfusion	YES NO	Heart Murmur	YES NO	Pain in Jaw Joints	YES NO	Tuberculosis	YES NO
Breathing Problem	YES NO	Heart Trouble/Disease	YES NO	Parathyroid Disease	YES NO	Tumors or Growths	YES NO
Cancer	YES NO	Hemophilia	YES NO	Psychiatric Care	YES NO	Vertigo	YES NO
Chemotherapy	YES NO	Hepatitis A	YES NO	Radiation Treatments	YES NO		
Cold Sores/Fever Blisters	YES NO	Hepatitis B or C	YES NO	Recent Weight Loss	YES NO		

If you have ever had any other serious illness not listed above, please list: _____

**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**_____

DENTAL TREATMENT CONSENT FORM

Please read and initial the items below and read and sign the bottom of form.

X-Rays *(Initials)* _____

Photos

Any photos taken will be part of my dental record. I understand that they may be used for case presentations, clinic promotion, and continuing education within the Community Dental Clinic as well as outside providers to whom I may be referred. I understand that I will not be compensated for the use of these photos.
(Initials)_____

Medications

I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissue, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). ***(Initials)***_____

Changes in Treatment Plan

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. ***(Initials)***_____

Nitrous Oxide

I understand that nitrous oxide (laughing gas) provides relaxation that may make it more comfortable for me to receive the necessary dental treatment needed with less anxiety. I will be awake, fully conscious, aware of my surroundings, and able to respond rationally. I have informed the doctor of my complete medical history including any recent surgeries or changes.
(*Initials*)_____

Local Anesthetic

I understand that there are risks of local anesthesia that may affect my body such as dizziness, nausea, vomiting, accelerated heart rate, slow heart rate, or various types of allergic reactions. It may also cause injury to nerves that can result in pain, numbness, tingling that may persist for several weeks, months, or rarely, be permanent. I have informed my doctor of my complete medical history including any recent surgeries or changes.
(Initials)_____

Restorations (Fillings)

I understand that care must be exercised in chewing on fillings especially during the first 24 hours to avoid breakage. I understand that a more expensive filling than is initially diagnosed may be required due to additional decay. I understand that significant sensitivity is a common after effect of a newly placed filling.
(Initials)_____

Removal of Teeth

Alternatives to removal have been explained to me and I authorize the dentist to remove any teeth necessary for reasons explained to me. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue, and surrounding tissue that can last for an indefinite period of time, or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility***. (Initials)***_____

Periodontal Loss (Tissue & Bone)

I understand that Periodontal Disease can be a serious condition, causing gum and bone inflammation and/or may lead to loss of permanent teeth. Possible treatment will be explained to me that may include deep tissue cleaning, gum surgery, extraction of teeth, and tooth replacement. I understand that much of the success of periodontal treatment depends on my continuing home care and strict observance of recall appointments. I understand that care by a specialist may be necessary. ***(Initials)***_____

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized.
I CERTIFY THAT I HAVE HAD AN OPPORTUNITY TO READ AND FULLY UNDERSTAND THE TERMS WITHIN THE ABOVE CONSENT AND EXPLANATION MADE AND THAT ALL STAEMENTS REQUIRING COMPLETION WERE FILLED IN BEFORE I SIGNED. I HAVE THE OPPORTUNTIY TO HAVE ALL MY QUESTIONS ANSWEREED BY MY DOCTOR AND I CERTIFY THAT I UNDERSTAND, SPEAK, READ, AND WRITE IN MY DESIGNATED LANGUAGE AND CAN PLAINLY SEEE THESE WORDS WHICH I AM READING. MY SIGNATURE BELOW SIGNIFIES THAT I UNDERSTAND THE TREATMENT AND ANESTHESIA THAT IS PROPOSED FOR ME, TOGETHER WITH THE KNOWN RISKS AND COMPLICATIONS ASSOCIATED WITH THAT TREATMENT. I HEREBY GIVE CONSENT FOR THE TREATMENT I HAVE CHOSEN.

PLEASE ASK YOUR DOCTOR IF YOU HAVE ANY QUESTIONS ABOUT THIS CONSENT FORM.

_____ _____

Patient's (Or Legal Guardian's) Signature **DATE**

Your Rights
The following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information.
Under federal law, however, you may not inspect or copy the following records:
Psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information.
This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to have your physician amend your protected health information.
If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint**.

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objection to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at (270)691-6205.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

Printed Name:_____ Signature:_____ Date:_____

Community Dental Clinic
2811 New Hartford Road, Suite A
Owensboro, KY 42303
270-691-6205

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient Name:_____

Patient Address:_____

I authorize the professional office of my dentist named above to release health information identifying me under all circumstances pertaining to my dental care (including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services) under the following terms and conditions:

1. Information will be provided to allow authorization and payment of services.

2. We may call or send reminders of appointments, we may disclose certain information to your pharmacy if medications are needed, and we may need to disclose personal and health information if necessary to refer for dental services not offered in our facility.

3. In all instances, Community Dental Clinic will show prudence and release only the minimum protected information necessary to a particular disclosure.

4. This authorization will expire if or when a written or electronic note is received.

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization. Please be advised that if you refuse to sign this authorization, you will be financially responsible for any services provided since we will not be able to submit claims to your insurance provider. You also forfeit being able to receive any prescriptions from our office.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office address listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Dated: _____Patient (or Legal Guardian) Signature: _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient: _____ Print Name: _____

Source of Authority (If not a Parent/Guardian) _____

Patient Name:	**Date**:

I give my permission for the following individuals to bring the above named patient to dental appointments at the Community Dental Clinic and to make any necessary medical/dental decisions for treatment.

Must be 18 years of age or older & have a valid ID.

Name:	Phone #:	Relationship to Patient:

I understand that individuals must present a valid ID when sigining in for the appointment.

I also understand that I must provide written notice if the individuals listed above are no longer allowed to escort the patient to the appointment.

Print Name:	Relationship to Patient:
Signature:	Date: