Patient Registration Form

Buford Family Dental

Date of Appointment: _____

Patient Information

Patient's First Name		Middle Name	Last Name (as it appears on insurance card or ID)
Sex	Marital Status	Date of Birth(Age)	Social Security Number

Patient's Address	City	State	Zip

Home Phone	Mobile Phone	Email Address
Referred by		

Patient Employer/School Information

Employer/School	Occupation	Employer/School Phone

Employer/School Address	City	State	Zip

Emergency Contact Information

Emergency Contact Name	Emergency Contact Phone	Relation to Patient

Responsible Party

Billing Name (if other than patient)	Phone	Relation to Patient

Address	City	State	Zip

Financial Policy

Thank you for choosing Buford Family Dental as your dental healthcare provider. We are committed to providing you with the highest quality of lifetime dental care. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment. Please note that payment of your bill is considered part of your treatment. Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, Amex, and Discover.

Please note: Returned checks are subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance, you will be responsible for any collection and/or legal charges up to 35%.

We will help you process your insurance claims. As a courtesy to you, we will provide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid. We will do what we can to make sure your estimate is accurate.

All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you and not with your insurance company. Your insurance policy is a contract between you and your insurance company. Our office is not a party to that contract.

Our practice is committed to providing the best treatment for our patients and we charge what is customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

We ask that you sign this form and any other necessary documents that may be required by your insurance company. This for instructs your insurance company to make payment directly to our office.

We ask that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance company by cash, check, MasterCard, Visa, Amex, or Discover when we provide the service to you.

Insurance payments are usually received within 30-60 days from the time of filing. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount.

We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not enter into a dispute with your insurance company over any claim.

Outside financing is available upon request and approval. Please check if you are interested in information on financing options. (INSERT BOX)

I have read, understand, and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that responsibility for payment for dental services provided in this office for my dependents or myself is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge, and attorney's fees will be added to any overdue balance.

By signing below, you are authorizing us to call you at any number you provide including calls to mobile/cellular or similar devices for any lawful purpose. You agree to any fees or charges that you may incur for an incoming call from us, and/or outgoing calls to us, to or from any such number, without reimbursement from us.

_____ _____

Signature of Patient or Authorized Guardian Date

Buford Family Dental

Reason for Visit

What brings you to the office?

Allergies

Are you allergic to any of the following?

- ☐ Adhesive Tape
- ☐ Antibiotics
- ☐ Latex
- ☐ Barbiturates (Sleeping Pills)
- ☐ Aspirin
- ☐ Iodine
- ☐ Codeine
- ☐ Sulfa
- ☐ Local Anesthetics

Do you have any other allergies?

Name _____ Reaction _____

Name _____ Reaction _____

Current Medications

Are you currently taking any blood thinners?

☐ Yes ☐ No

Are you currently taking any osteoporosis medications?

☐ Yes ☐ No

What medications are you currently taking?

Name _____ Dosage _____ Frequency _____

Name _____ Dosage _____ Frequency _____

Name _____ Dosage _____ Frequency _____

Hospitalizations &Surgeries

Reason _____ Date _____

Reason _____ Date _____

Reason _____ Date _____

Dental History

When was your last dental exam?

Date _____

When were your last dental x-rays taken?

Date _____

How often do you brush? #times/day _____

How often do you floss? #times/day _____

Do you grind your teeth?

☐ Yes ☐ No

Have you ever had orthodontic (braces) treatment?

☐ Yes ☐ No

Have you ever had periodontal (gum) treatments?

☐ Yes ☐ No

Do you have any of the following?

- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ Blisters on Mouth
- ☐ Broken Fillings
- ☐ Clicking Jaw
- ☐ Dentures
- ☐ Difficulty Opening or Closing
- ☐ Dry Mouth
- ☐ Difficulty Chewing
- ☐ Ear Pain
- ☐ Jaw Pain
- ☐ Loose Teeth
- ☐ Mouth Pain
- ☐ Mouth Sores
- ☐ Partials
- ☐ Sensitivity to Cold
- ☐ Sensitivity to Heat
- ☐ Sensitivity to Sweets
- ☐ Sensitivity to Pressure
- ☐ Swollen Gums

Past Medical History

Have you ever had any of the following?

- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ AIDS/HIV
- ☐ Bleeding Disorder
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Bowel Disorder
- ☐ Cancer
- ☐ Diabetes
- ☐ Depression
- ☐ Eating Disorder
- ☐ Epilepsy
- ☐ Hay Fever
- ☐ Heart Disease
- ☐ Heart Problems
- ☐ Hepatitis-A,B,or C
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Joint Disorder
- ☐ Kidney Disorder
- ☐ Liver Disorder
- ☐ Lung Disease
- ☐ Lupus
- ☐ Measles
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Skin Disorder
- ☐ Stroke
- ☐ Stomach Ulcer
- ☐ Substance Abuse
- ☐ Thyroid Disorder
- ☐ Tuberculosis
- ☐ Venereal Disease

Cosmetic Dentistry

Are you interested in whitening your teeth?

☐ Yes ☐ No

Are you interested in straightening your teeth with invisible braces?

☐ Yes ☐ No

Women Only

Are you pregnant?

☐ Yes ☐ No

Are you breastfeeding?

☐ Yes ☐ No

Printed Name of Patient _____ Date _____

Signature of Patient or Authorized Guardian _____ Signature of Doctor _____

Notice of Privacy Practices Summary

This describes how health data about you may be used and shared and how you can get access to this data.

I. How we may use health data about you:
   a. Treatment – We may use or share your health data to give you medical treatment or other types of health services.
   b. Payment – We may use or share your health data to bill you or a third party for payment for services provided to you.
   c. Health Care Operations – We may use and share health data about you for our own operations such as quality control, compliance monitoring, outcome evaluation, audit, etc.

II. Disclosures where we do not have to give you a chance to agree or object:
   a. To you
   b. As required by federal, state, or local law
   c. If child abuse or neglect is suspected
   d. Public Health risks for public health activities to prevent and control of disease.
   e. Lawsuits and disputes in response to a court or administrative order.
   f. Law enforcement to help law enforcement officials respond to criminal activities.
   g. Coroners, medical examiners, and funeral directors
   h. Organ or tissue donation facilities if you are an organ donor
   i. To avert a threat to individual or public health or safety

III. Disclosures where we have to give you a chance to agree or object:
   a. Patient directories – You can decide what health data, if any, you want to be listed in patient directories.
   b. Persons involved in your care or payment for your care – We may share your health data with a family member, a close friend or other person that you named as being involved with your health care.

IV. Other uses of health data: Other uses not covered by this notice or the laws that apply to us will be made only with your written consent.

V. You have these rights for the health data we keep about you:
   1. Right to inspect your health record and to receive a copy of your health record upon request.
   2. Right to amend information in your health record you believe is inaccurate or incomplete.
   3. Right to know to whom we have disclosed your health information.
   4. Right to ask for limits on the health information data we give out about you.
   5. Right to receive communication from us about your health information in alternate ways.
   6. Right to a paper copy of the complete Notice of Privacy Practices.

Notice of Privacy Practices Receipt

I acknowledge that I have received the Notice of Privacy Practices of Buford Family Dental.

Signature of Patient or Representative _____

Print Patient Name _____ Date:_____