



NEW PATIENT REGISTRATION

Patient: _____ Preferred Name: _____
Last Name First Name Middle Initial

Home #: _____ Work #: _____ Cell #: _____

Email Address: _____

The best way to contact me is through: Text Email Cell Home Work No preference

Home Address: _____

City: _____ State: _____ Zip: _____

DOB: ____ / ____ / ____ Social Security #: _____ Male Female / Single Married
MM DD YYYY

Employer: _____ Spouse Name: _____ Spouse's Employer: _____

Alternate Contact (Outside of Home/Spouse): _____

Who can we thank for referring you to our office? _____

PERSON RESPONSIBLE FOR ACCOUNT: _____ Address: _____

Method of Payment (After Insurance Payments): Cash/Check Credit Card Third Party Financing

PRIMARY DENTAL INSURANCE: Company Name: _____

Subscriber's Name: _____ DOB: ____ / ____ / ____

Group # _____ ID# _____

SECONDARY DENTAL INSURANCE: Company Name: _____

Subscriber's Name: _____ DOB: ____ / ____ / ____

Group # _____ ID# _____

MEDICAL INSURANCE: Company Name: _____

Subscriber's Name: _____ DOB: ____ / ____ / ____

Group # _____ ID# _____

I authorize treatment by Laurel Dental Clinic and agree to pay all related professional fees. Fees not covered by my dental/medical insurance will be promptly paid upon notification from this office. I have received a copy of the office's financial policy and without reservation I agree to abide by the policies outlined herein.

Signature: _____ Date: _____

Patient Name: _____ Date of Birth: _____

Physician's name, phone, and date of last exam: _____

Yes No Do you take medications? If so, please list: _____

Yes No Do you have allergies (Penicillin, Codeine, Latex, etc.)? If so, please list: _____

Yes No Have you been hospitalized? If so, please list dates and reasons: _____

Do you have or have you ever had any of the following (if "Yes", please circle which):

- | | |
|--|--|
| Yes No Artificial joints (hip, knee, etc.) | Yes No Periodontal (gum) disease |
| Yes No High blood pressure / Angina / Arrhythmias | Yes No Family history of periodontal disease |
| Yes No Heart disease / Heart attack / Defibrillator | Yes No Cancer / Tumors |
| Yes No Artificial heart valve / Pacemaker | Yes No Chemotherapy / Radiation treatment |
| Yes No Bleeding disorders / Prolonged bleeding | Yes No Sinus problems / Ear problems |
| Yes No Anemia / Leukemia / Blood dyscrasias | Yes No Asthma / Tuberculosis / Lung disease |
| Yes No Stroke / Aneurysm | Yes No Arthritis / Lupus |
| Yes No Seizures | Yes No Anxiety / Depression / Psychiatric treatment |
| Yes No Hepatitis / Liver disease / Kidney problems | Yes No Dental anxiety |
| Yes No HIV / AIDS | Yes No Sleep Apnea |
| Yes No Ulcers / Stomach problems | Yes No TMJ Pain / Disorder |
| Yes No Osteoporosis / Bone disease | Yes No Tobacco use |
| Yes No Diabetes / Family History of Diabetes | Yes No Drug / Alcohol abuse |
| Yes No Thyroid / Adrenal problems | Yes No Currently Pregnant / Nursing |

Yes No Any other medical problems? If so, please describe: _____

Yes No Do you prefer some form of sedation for dental procedures? If "Yes", please circle which
 Nitrous oxide (laughing gas) Oral sedation IV sedation

Yes No Is there anything you would like to change about your smile/teeth? _____

How often do you: brush your teeth _____ floss your teeth _____

To the best of my knowledge, I have filled out this Health History Form completely and accurately.

Patient / Guardian Signature: _____ Date: _____

Hygienist/Assistant Signature: _____ Date: _____

Doctor Signature: _____ Date: _____



Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Laurel Dental Clinic. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Laurel Dental Clinic reserves the right to change the privacy practices currently described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed or otherwise transmitted to me.

ADDITIONAL DISCLOSURE AUTHORIZATION		
<i>In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below. (I understand that the default answer is "NO". Without indicating "YES" in answer to the each individual question, personal protected (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)</i>		
Spouse only	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Any Member of my immediate family: (Spouse, Children, Children's Spouses)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Any Member of my extended family: (Parents, Grandchildren)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Other:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Name of patient (please print):		
Patient signature (if 18 years old or older):		
Patient's personal representative: (Please Print):		
Personal Representative's signature:		
Representative's Telephone Number:		Date:

FOR OFFICE USE ONLY BELOW THIS LINE

Acknowledgement Not Obtained			
Provided Prior to Treatment?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Date Statement Provided: _____
Reason for not obtaining Patient signature	<input type="checkbox"/>	Needed more time to review Statement of Privacy Practices	
	<input type="checkbox"/>	Wanted to consult another person before signing	
	<input type="checkbox"/>	Physically unable to sign	
	<input type="checkbox"/>	No reason offered	
	<input type="checkbox"/>	Other:	

APNEA SCREENING QUESTIONNAIRE

This questionnaire helps to determine your risk for having sleep apnea.

PATIENT NAME:	DATE OF BIRTH:	TODAY'S DATE:
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	YES	NO	NOT SURE
Have you ever had a sleep study? If so, When? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Were you diagnosed with Obstructive Sleep Apnea?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently using a CPAP device?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO	NOT SURE
Have you been told that (or noticed on your own) that you snore on most nights?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you been told (or noticed on your own) that you stop breathing or struggle to breathe in your sleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you tired, fatigued or sleepy on most days?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have <input type="checkbox"/> acid indigestion or <input type="checkbox"/> high blood pressure (or use medication to control either of these conditions?)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you overweight?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been told you have any of the following?:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Congestive Heart Failure			
<input type="checkbox"/> Coronary Artery Disease			
<input type="checkbox"/> Irregular Heart Rhythms (atrial fibrillation)			
<input type="checkbox"/> Stroke <input type="checkbox"/> Other _____			

<i>Internal Office Notes:</i>	
Height: _____	Weight: _____ BMI: _____ Neck Circumference: _____
Insurance: _____	Requires Prior Auth.? Y / N Screener Score: _____

FINANCIAL POLICY

We want you to feel comfortable with your dental care and that includes feeling satisfied with your financial arrangements. If you have any questions or concerns with this Financial Policy please do not hesitate to ask our business staff.

DENTAL INSURANCE: As a courtesy we will gladly file your claims and accept assignment of dental insurance benefits provided you agree to the following:

- Although we may estimate your insurance benefits we are not responsible for their accuracy. Knowledge of benefits as well as benefit amounts, limitations, exclusions, waiting periods, etc. is entirely your responsibility. Receiving our services indicates your acceptance of responsibility to pay regardless of our estimate.
- All charges not paid by your insurance are your responsibility regardless of the reason for nonpayment. Not all the services we provide are covered benefits. Benefits differ from one company to another. Fees for non-covered services, along with deductibles and co-payments are due at the time of treatment unless other payment arrangements have been made.

PATIENTS WITHOUT DENTAL BENEFITS: We provide written estimates of fees, and payment is expected at each visit for services rendered.

MINOR PATIENTS: The parent or guardian accompanying the minor is responsible for full payment. In the case of divorced or separated parents, the accompanying parent is responsible. This office will not attempt to collect payment from a parent that is not present in the office at that visit.

OVERDUE BALANCE: We understand temporary financial problems may affect timely payment of your balance. In those situations we ask that you communicate with us immediately so we may assist you in the management of your account. If there has been no communication concerning an unpaid balance after 90 days it will be sent to a collection agency.

BROKEN OR MISSED APPOINTMENTS: Appointments not kept or changed with less than 24 hours notice are considered broken. Please reschedule or cancel in advance to avoid a missed appointment fee of \$50.00. We reserve the right to terminate professional treatment of any patient when scheduled appointments are not kept.



LAUREL DENTAL CLINIC

ADVANCED FAMILY & COSMETIC DENTISTRY

104 West 3rd Street Port Angeles, WA 98362

Phone (360)452-9744 Fax (360) 452-5861

office@lauredentalclinic.net

AUTHORIZATION FOR RELEASE OF DENTAL RECORDS

- For transfer of records TO Laurel Dental Clinic
- For transfer of records FROM Laurel Dental Clinic

I, _____ (print name), hereby request the disclosure of information from my dental records on file with your office.

Patient Name: _____ Date of Birth: _____

Address: _____

Phone: _____

Previous Dental Office/Doctor: _____

Patient/ Guardian Signature: _____ Date: _____

TO BE COMPLETED BY PREVIOUS DENTIST

Date of Last Propy/ Perio Maintenance/ Scaling Root Planing:

Date of Last FMX/ Pano/ BWX:
