Patient Registration Form

Email:			Today's Date:	
Preferred Name: ☐Miss ☐Mr. ☐Mrs. ☐Dr.			Referred By:	
First Name:	Middle Name:	Last Name:		
Mailing Address:	City:	State:	Zip:	
SS#:	Date of Birth:	Sex: M F	Home Phone:	
Marital Status: ☐Married ☐Single ☐Divorced ☐Separated ☐Widowed			Cell Phone:	
Employer:	☐Full Time ☐Part Time ☐Retired		Work Phone:	
Preferred Pharmacy:				

Emergency Contact:		
Relationship:	Home Phone:	Cell Phone:

Dental Insurance

Name of Insured:	Patient Relationship to Insured: ☐Self ☐Spouse ☐Child ☐Other
Insured SS#:	Insured Birth Date:
Insurance Company Name:	
Subscriber ID:	Group #:

Acknowledgment of Financial Policy

Claims will be submitted to your insurance at the time of service; however, you are ultimately responsible for your own account balance. Most insurance companies do not cover 100% of all services; therefore, your "estimated" portion is due at time of service. Please be aware if any portion of your claim is denied, you are responsible for the balance. Statements are sent monthly, please notify us promptly if insurance payments have not been applied to your account within 45 days.

To better serve our patients we accept cash, personal check, Visa, Mastercard, Amex and Discover. Care Credit financing is available upon approval, offering no interest and extended payment plans with low interest. There is a $35 charge for any returned check.

We require a 48 hours' notice for appointment changes or cancellation. Broken or changed appointments without proper notice are subject to a $25 charge.

Patient or Guardian Signature:_____ Date:_____

Dental Information

	Yes	No
Do your gums bleed when you brush or floss?	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐
Is your mouth dry?	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐
Have you ever had braces?	☐	☐
Are you currently experiencing dental pain or discomfort?	☐	☐
Do you have earaches or neck pain?	☐	☐
Do have any clicking, popping or discomfort in the jaw?	☐	☐
Do you wear dentures or partials?	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐

Allergies	Yes	No	DK
Local anesthetics	☐	☐	☐
Aspirin	☐	☐	☐
Penicillin or other antibiotics	☐	☐	☐
Barbiturates or Sedatives	☐	☐	☐
Sulfa Drugs	☐	☐	☐
Codeine or other narcotics	☐	☐	☐
Metals	☐	☐	☐
Latex (rubber)	☐	☐	☐
Hay Fever / Seasonal	☐	☐	☐
Food:_____	☐	☐	☐

Last Dental Visit:_____

Other Allergies:_____

Medical Information

Check all that apply or circle: **NONE**

☐ Abnormal Bleeding	☐ Chronic Pain	☐ Heart Attack	☐ Pacemaker
☐ AIDS or HIV	☐ Congenital Heart Defects	☐ Heart Murmur	☐ Rapid Weight Loss
☐ Anemia	☐ Congestive Heart Failure	☐ Hemophilia	☐ Recurrent Infections
☐ Angina	☐ Coronary Artery Disease	☐ Hepatitis/Liver Disease	☐ Rheumatic Fever
☐ Arteriosclerosis	☐ Damaged Heart Valves	☐ High Blood Pressure	☐ Rheumatic Heart Disease
☐ Arthritis	☐ Diabetes Type I or II	☐ Kidney Problems	☐ Rheumatoid Arthritis
☐ Artificial Heart Valves	☐ Eating Disorder	☐ Low Blood Pressure	☐ Sinus Trouble
☐ Asthma	☐ Emphysema	☐ Malnutrition	☐ Sleep Disorder
☐ Autoimmune Disease	☐ Excessive Urination	☐ Mental Health Disorders	☐ Sexually Transmitted Disease
☐ Blood Transfusion Date: _____	☐ Epilepsy	☐ Migraines/ Severe Headaches	☐ Stroke
☐ Bronchitis	☐ Fainting Spells or Seizures	☐ Mitral Valve Prolapse	☐ Systemic Lupus Erythematosus
☐ Cancer/Chemotherapy	☐ G.E. Reflux/Heartburn	☐ Neurological Disorders	☐ Thyroid Problems
☐ Cardiovascular Disease	☐ Gastrointestinal Disease	☐ Night Sweats	☐ Tuberculosis
☐ Chest Pain	☐ Glaucoma	☐ Osteoporosis	☐ Ulcers

Other medical problems not listed: _____

Please list any medications you are taking:_____

Circle Yes or No.

Have you ever had an orthopedic total joint replacement (hip, knee, elbow, finger)? **Yes No** Date:_____

Have you ever had a serious illness, operation or been hospitalized in the past 5 years? **Yes No** What was treated:_____

Do you use tobacco (smoking, snuff, chew, bidis)? **Yes No**

Are you now under the care of a physician? **Yes No** Physician Name:_____

Are you in good health? **Yes No**

Woman Only

Are you Pregnant? **Yes No**

Number of weeks:_____

Are you taking birth control pills or hormone replacement? **Yes No**

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian:_____ Date:_____

DON LEE DMD PA
531 S Bickett Blvd
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919-496-5734

OUR DENTAL OFFICE PRIVACY POLICY

As Dental professionals, Dr. Lee and his staff implemented this Health Information Privacy Policy and Procedures to protect the interest of our patients and to fulfill our legal obligations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the amended modification of 2002 and state law that provide greater information are important to us. We will not use your health information for marketing or communications. Your health information may be used:

- By other dental specialists if you are referred
- To provide you with appointment reminders
- By you or anyone you designate in writing
- To obtain payment for services we have provided for you
- When required by law

As a patient you have a right to view or transfer your dental records. If you want more information about the privacy practices of this dental office, or if you are concerned that we may have violated your privacy rights, please contact our office or the U.S. Department of Health and Human Services. We support your right to the privacy of your health information.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of this office's Notice of Privacy Practices.

_____
Print Your Name/Date

_____
Signature/Date

AUTHORIZATION FOR ADDITIONAL DISCLOSURE

I authorize the following individuals to have access to my health information:

_____ _____
Name Relationship

_____
Your Signature/Date

General Consent Form for Dental Treatment

Patient Name: _____

Please read this form before you sign it.

I understand that:

- It is important to inform the dentist of my medical history and the medicines I take as some medications can cause harmful reactions with dental anesthetics, analgesics, antibiotics, or other medications.
- Sensitivity may occur on a newly placed filling. Chewing in the area of a restoration could cause breakage or soft tissue damage.
- During treatment it may be necessary to change or add procedures because of conditions found while working on my teeth that were not discovered during examination.
- Diagnostic x-rays provide the dentists with valuable information about my teeth and supporting bone that cannot be evaluated otherwise. Without these x-rays a complete exam cannot be done. X-rays will not be released to anyone without my permission.
- Complications may arise from the use of dental instruments, drugs, sedation, medicines, analgesics (pain killers), anesthetics, and injections. These include (but are not limited to) swelling, sensitivity, bleeding, pain, infection, numbness and tingling sensation in the lip, tongue, chin, gums, cheeks, and teeth (which is transient but on infrequent occasion, may be permanent).
- This dental practice must receive written consent prior to performing any non-emergency dental procedures on a minor not accompanied by a parent or legal guardian. Without written consent the minor's appointment will be rescheduled.
- If I request only a specific problem be addressed (i.e.: broken tooth, pain in one area, etc.), it is considered a problem focused evaluation. X-rays will be taken in this specific area only, and a complete comprehensive examination will not be done. The dentist cannot diagnose problems in other areas of my mouth. This appointment will be for the treatment/diagnosis of an emergency/urgent need. Any future treatment of other areas will require additional x-rays and a complete exam.

Note: General dentists perform the majority of all dental treatment today. However, we want all patients to be aware that specialty fields exist in dentistry, particularly in the fields of oral surgery, orthodontics, periodontics, pediatric dentistry, and endodontics. In some cases, we may have to refer certain procedures out to a specialist.

I give my consent to any advisable and necessary dental procedures, medications, or anesthetics to be administered by the attending dentist or by the supervised staff for diagnostic purposes or dental treatment. 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 that I have requested and authorized.

Patient or Guardian Signature:_____ Date:_____

Witness Signature:_____ Date:_____