



PATIENT REGISTRATION

Welcome! We want to provide you with the best possible care. Please assist us by thoroughly answering all the questions below. All information is completely confidential.

NAME _____ Birth date _____ Age ____ SSN _____

Preferred name _____

Street _____ Phone# _____

City _____ Cell # _____

State _____ Zip _____ E-mail _____

Employer _____ How long held? _____

Insurance _____ Group No. _____

Insurance I.D. No. _____

SPOUSE NAME

(or parent/guardian if above is a child) _____ Birth date _____ Age ____ SSN _____

Street _____ Phone# _____

City _____ Cell # _____

State _____ Zip _____ E-mail _____

Employer _____ How long held? _____

Insurance _____ Group No. _____

Insurance I.D. No. _____

In case of emergency, who should be notified? _____

Phone _____ Relation _____

BILLING INFORMATION

Person responsible for account _____ Relationship to patient _____

Address _____ City _____ State _____ Zip _____

Phone _____ E-mail _____

If using charge card, Name _____ Card No. _____ Exp. Date _____

Who may we thank for referring you? _____

Signature _____ Date _____

this space is intentionally left blank

CONSENT FOR TREATMENT

I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of (name of patient)_____’s dental needs.

Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents or medication carries certain risks. I understand that I can ask for a complete recital of any possible complications.

I give consent to the doctor’s or designated staff’s use and disclosure of any oral, written or electronic records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a late charge (12 % APR) may be added to my account. If required, I also understand a check of my credit history be made.

Patient’s signature_____ Date _____

Parent/Responsible party’s signature_____ Relationship to Patient_____



DENTAL HISTORY

Name _____ Date _____ Birth date _____ Age _____

Please answer each of the following questions. If in doubt, please leave blank.

1. Reason for appointment _____

2. Date of last dental visit _____ Last Cleaning _____ X-Rays _____

Previous dentist's name _____

Address _____ State _____ Zip _____

3. Do you have any dental problems now? YES NO

Please describe _____

4. What issues do you want to address today? _____

YES NO

Are your teeth sensitive?
If yes, please describe _____

Have your parents experienced gum disease or tooth loss?

Do you frequently get cold sores, blisters or other oral lesions?

Have you noticed loose teeth or any change in your bite?

Does food tend to be caught in between your teeth?
If yes, where? _____

Do you clench or grind your teeth while awake or asleep?

Do you breathe through your mouth?

Do you have tired jaws, especially in the morning?

Do you snore or have sleeping disorders?

Do you smoke/chew tobacco or use other products?

Have you seen a dental specialist?

Have you had a serious injury to the mouth or head?
If yes, please describe _____

YES NO HAVE YOU EXPERIENCED?

Clicking or popping of the jaw?

Pain? (joint, ear, side of face)

Difficulty in opening/closing mouth?

Headaches, neck aches or shoulder aches?

Sore muscles (neck, shoulder)

Do you feel nervous about having a dental treatment?
If yes, please describe _____

Have you ever had an upsetting dental experience?
If yes, please describe _____

What can we do to make your dental visits more pleasant?
Please describe _____

5. What are your long term desires for your teeth/dental health?

6. Have you ever been told that you needed to be pre-medicated with antibiotics prior to treatment? YES NO

7. Rate the health of your mouth now POOR -- 1 2 3 4 5 -- EXCELLENT

8. Rate the satisfaction of your smile UNSATISFIED -- 1 2 3 4 5 -- HIGHLY SATISFIED

For doctor/staff use only

HEALTH HISTORY

Please take the time to completely answer the following questions. All information is completely confidential. Doing so will allow your dentist and staff to treat you appropriately, according to your needs.

Name _____ Date _____ Birth date _____ Age _____

Please answer each of the following questions. If in doubt, please leave blank.

- | | YES | NO |
|---|--------------------------|--------------------------|
| 1. Are you in good health now? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are you under the care of a physician? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, what is the condition being treated? _____ | | |

3. Physician's Name _____ Phone _____

4. Do you have or have you ever had any of the following?

YES	NO	GENERAL			RESPIRATORY			DIGESTIVE SYSTEM
<input type="checkbox"/>	<input type="checkbox"/>	Tire easily, weakness	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	Marked weight change	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice
<input type="checkbox"/>	<input type="checkbox"/>	On a diet	<input type="checkbox"/>	<input type="checkbox"/>	Asthma/hayfever	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers
<input type="checkbox"/>	<input type="checkbox"/>	Supervised diet	<input type="checkbox"/>	<input type="checkbox"/>	Persistent cough	<input type="checkbox"/>	<input type="checkbox"/>	Change in appetite
<input type="checkbox"/>	<input type="checkbox"/>	Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	Bloody sputum			URINARY
<input type="checkbox"/>	<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty breathing while lying down	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease
		SKIN						Increase in frequency of urination
<input type="checkbox"/>	<input type="checkbox"/>	Rash/hives			ENDOCRINE			Bloody urine
<input type="checkbox"/>	<input type="checkbox"/>	Change skin color	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Venereal disease
		EYES	<input type="checkbox"/>	<input type="checkbox"/>	Family history of diabetes	<input type="checkbox"/>	<input type="checkbox"/>	BLOOD
<input type="checkbox"/>	<input type="checkbox"/>	Visual change	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid condition/goiter			Bruise easily
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma			HEART/BLOOD VESSELS	<input type="checkbox"/>	<input type="checkbox"/>	Anemia
		EARS	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	Blood transfusions
<input type="checkbox"/>	<input type="checkbox"/>	Loss of hearing	<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	OTHER
<input type="checkbox"/>	<input type="checkbox"/>	Ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain/discomfort			Radiation therapy
		NOSE	<input type="checkbox"/>	<input type="checkbox"/>	Heart attack/trouble	<input type="checkbox"/>	<input type="checkbox"/>	Tumors or growths
<input type="checkbox"/>	<input type="checkbox"/>	Frequent nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	<input type="checkbox"/>	Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of ankles	<input type="checkbox"/>	<input type="checkbox"/>	2+ drinks/day
		THROAT	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol dependency
<input type="checkbox"/>	<input type="checkbox"/>	Soreness/hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco dependency
		NERVOUS SYSTEM	<input type="checkbox"/>	<input type="checkbox"/>	Congenital heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Drug dependency
<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Artificial heart valve	<input type="checkbox"/>	<input type="checkbox"/>	AIDS/ARC, HIV
<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Ever had a serious illness
<input type="checkbox"/>	<input type="checkbox"/>	Convulsions/epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Heart surgery	<input type="checkbox"/>	<input type="checkbox"/>	Ever had a serious accident
<input type="checkbox"/>	<input type="checkbox"/>	Numbness/tingling	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	Ever had excessive
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness/fainting			BONE/MUSCLES	<input type="checkbox"/>	<input type="checkbox"/>	bleeding after extraction
<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric treatment	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/rheumatism			Cuts take long time to heal
			<input type="checkbox"/>	<input type="checkbox"/>	Artificial joints	<input type="checkbox"/>	<input type="checkbox"/>	

5. Are you pregnant? YES NO
 If yes, what month? _____
 Are you taking birth control pills? YES NO

6. Are you allergic or have you ever experienced any

reaction to the following?	YES	NO
Local anesthetics (e.g. novocaine)	<input type="checkbox"/>	<input type="checkbox"/>
Barbituates/sedatives/sleeping pills	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin/sulfa/other antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin or codeine	<input type="checkbox"/>	<input type="checkbox"/>
Latex	<input type="checkbox"/>	<input type="checkbox"/>
Other allergies _____		

6. Are you taking any of the following? YES NO
- | | | |
|--|--------------------------|--------------------------|
| Antibiotics/sulfa drugs | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood thinners | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood pressure medication | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid medication | <input type="checkbox"/> | <input type="checkbox"/> |
| Cortisone/steroids | <input type="checkbox"/> | <input type="checkbox"/> |
| Antihistamines/allergy drugs/cold remedies | <input type="checkbox"/> | <input type="checkbox"/> |
| Insulin/other diabetes drugs | <input type="checkbox"/> | <input type="checkbox"/> |
| Recreational drugs | <input type="checkbox"/> | <input type="checkbox"/> |
| Digitalis/other heart medications | <input type="checkbox"/> | <input type="checkbox"/> |
| Nitroglycerin | <input type="checkbox"/> | <input type="checkbox"/> |
| Aspirin/ibuprofen/acetaminophen | <input type="checkbox"/> | <input type="checkbox"/> |
| Fossamax, Boniva, Actonel, Zometa? Please specify. | | |
| Other medication _____ | | |

If yes to any of the above, list name of medication and dosage below.

1. _____ 2. _____
 3. _____ 4. _____

7. Is there any disease, condition or problem not listed above that you think we should know about or any activity you cannot do? If so explain _____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or change in my medication, I will inform the dentist at my next appointment.

Signature of Patient (or Parent or Guardian) _____

For doctor/staff use only



FINANCIAL POLICY

Dental treatment is an investment in your general and dental health. We want to assist you in making financial arrangements and submitting your insurance claims. We will work with you to make financial arrangements as simple as possible.

Payment for services is due at the time they are performed unless you have a prearranged financial payment plan with our office.

If you have dental insurance, please remember that you need to understand the provisions and limitations of your plan. Reading your insurance plan booklet and talking directly with your insurance company are the best ways to inform you of the services the plan covers. Doing so before treatment begins will help prevent misunderstandings.

Insurance companies have set a trend of continuing to decrease the number and percentage of covered services without informing dental providers. Please remember that your dental insurance is a contract between you and your insurance company and that you are ultimately responsible for the charges not covered by the insurance plan. Thank you for your understanding.

As a courtesy to you, we will bill your insurance company directly. We require payment of your share of the treatment charges at each appointment. If we do not receive payment from your insurance in 90 days, the balance is then your responsibility and due in full. If your insurance plan should pay more than the estimated costs we will send you a refund within 30 days of the insurance payment.

We accept cash, checks, VISA, MasterCard and Discover.

We charge 12% interest annually after 90 days.

We charge \$25.00 for a returned check from your bank.

Because we schedule one-on-one time with each patient, we require a 24 hour notice if you are unable to make your appointment. Failure to do so will result in a \$75 charge to your account.

We believe regular visits and preventative treatment are your best protection against long and costly procedures. However, when the costs of necessary treatment exceed your budget, we can help you create a financial payment plan prior to beginning treatment.

Patient Signature

Date



PRIVACY PRACTICES

Office of Dr. Kent Nuttall
Patient record of disclosures & acknowledgement

Our Privacy Policy describes in more detail how your health information may be used and disclosed and how you can access your information. A link to our Privacy Policy is found on the bottom of our website homepage. Please read our Privacy Policy and by your signature below acknowledge receipt thereof.

The HIPAA privacy rule gives patients the right to request a restriction on uses and disclosures of their protected health information (PHI). The patients are also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the patient's office instead of their home.

I wish to be contacted in the following manner (check all that apply):

- | | |
|--|--|
| <input type="checkbox"/> Home telephone | <input type="checkbox"/> Work phone |
| <input type="checkbox"/> OK to leave message with detailed information | <input type="checkbox"/> OK to leave message with detailed information |
| <input type="checkbox"/> Leave message with callback only | <input type="checkbox"/> Leave message with callback only |
| <input type="checkbox"/> Cell phone | <input type="checkbox"/> Written Communication |
| <input type="checkbox"/> OK to leave message with detailed information | <input type="checkbox"/> OK to mail to my home address |
| <input type="checkbox"/> Leave message with callback only | <input type="checkbox"/> OK to mail to my work address |

Print Name _____

Patient Signature _____

Date _____

The Privacy Rule generally requires dental healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to and authorization requested by the patient.

Dental healthcare providers must keep the records of PHI disclosures information provided below, if completed properly, will constitute an adequate record.

NOTE: Uses and disclosures may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Dental Health Information

<i>Date</i>	<i>Address or Fax # Disclosed to whom</i>	<i>Purpose of disclosure Description of disclosure</i>	<i>By whom disclosed</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____