Registration Form

PERSONAL INFORMATION

PATIENT'S LAST NAME FIRST INT.

DATE OF BIRTH (CIRCLE ONE) MALE FEMALE

MARITAL STATUS (CIRCLE ONE) SINGLE MARRIED OTHER

SPOUSE'S NAME

SOCIAL SECURITY NUMBER DRIVER'S LICENSE NUMBER

HOW DO YOU WISH TO BE ADDRESSED?

IF CHILD, PARENT'S LAST NAME FIRST INT.

HOME ADDRESS

STREET CITY/STATE/ZIP

PHONE CELL PHONE PAGER

EMAIL ADDRESS

BEST WAY TO CONTACT YOU REGARDING APPOINTMENTS, TREATMENT, ETC.? (CIRCLE ONE)

PHONE (HOME OR WORK) CELL PHONE PAGER EMAIL

PERSON TO CONTACT IN CASE OF EMERGENCY

NAME

RELATIONSHIP PHONE

CLOSEST RELATIVE NOT LIVING WITH YOU

NAME

RELATIONSHIP PHONE

STREET CITY/STATE/ZIP

YOUR FORMER ADDRESS

STREET CITY/STATE/ZIP

WHO DO WE THANK FOR REFERRING YOU?

IS THERE ANOTHER FAMILY MEMBER OR RELATIVE WHO IS A PATIENT OF DR. DAYTON'S?

WORK INFORMATION

EMPLOYER

BUSINESS ADDRESS CITY/STATE/ZIP

PHONE CELL PHONE PAGER

EMAIL ADDRESS

DENTAL INSURANCE INFORMATION

EMPLOYER NAME

EMPLOYEE NAME DATE OF BIRTH

INSURANCE COMPANY POLICY NUMBER

EMPLOYEE SOCIAL SECURITY NUMBER

ACCOUNT INFORMATION

WHO IS RESPONSIBLE FOR THIS ACCOUNT?

RELATIONSHIP TO PATIENT

SOCIAL SECURITY NUMBER DRIVER'S LICENSE NUMBER

RELEASE

I authorize the dentist to perform diagnostic procedures and treatments as may be necessary for proper dental care.

I authorize release of any information concerning my (or my child's) health care, advise, and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I acknowledge that I am responsible for all costs of dental treatment.

I attest to the accuracy of the above information.

I understand that a fee of $200 per hour will be charged to me for not giving a 3 business day notice for any changes in scheduling with Dr. Dayton and a $50 per hour fee with our dental hygienist. In some instances a deposit of $400 will be required and not refunded without the same 3 business day notice. I am aware that I am responsible for all fees incurred-to collect my financial obligation.

SIGNATURE DATE

REVIEWED AND VERIFIED BY STAFF DATE

Dental History

DATE

PATIENT'S NAME DATE OF BIRTH

What is the purpose of your visit? ____

Are you aware of a problem? ____

How long since your last dental visit? ____

What was done? ____

Your previous dentists name? ____

Any past experiences (likes/dislikes) we should know about? ____

CIRCLE THE APPROPRIATE ANSWERS

1. Are any of your teeth sensitive to:
   a) Hot b) Cold c) Sweets d) Pressure e) Chewing f) Other ____
2. Have you noticed any: a) Bad Tastes b) Mouth Odors c) Blisters d) Cold Sores
   e) Swelling Lumps f) Loose Teeth g) Changes in Your Bite h) Discolored Gums
   i) Bleeding/Sore Gums j) Food Caught Between Teeth k) Other ____
3. Have you ever had: a) Orthodontics (Braces) b) Oral Surgery c) Periodontics (Gum Tx)
   d) Bite Adjusted e) Endodontics (Root Canal) f) Mouth Guard
4. Have you experienced: a) Headaches/Neckaches b) Tired/Sore Jaws c) Clenching/Grinding Teeth
   d) Joint/Ear Pain e) Clicking/Popping Jaw f) Chewing Problems
5. Which of the following do you use: a) Toothbrush: Hard Medium Soft b) Floss c)
   Other____
6. My mouth is: a) Very Comfortable b) Moderately Comfortable c) Uncomfortable
7. The appearance of my mouth is: a) Excellent b) Good c) Poor
8. Keeping my natural teeth is: a) Very Important b) Not Important c) Important, but____
9. I have: a) Always done what my dentist recommends b) Usually done what was recommended
   c) Rarely go and don't care to have dental work done
10. I put dentistry for me and my family: a) High on my priority list b) Low on my priority list
    c) On my list but hard to find
11. The diagram below represents a continuum of dental care. Please place an ***X*** on the diagram where you feel your level of dental care currently exists in your mouth, today. Please place an ***O*** where you would like to see your level of oral health in five to ten years. Please place an ***I*** where you believe your dental insurance reimbursement pays.

POOR	AVERAGE	EXCELLENT

PATIENTS SIGNATURE DATE

NOTES

DOCTORS SIGNATURE DATE

Medical History

Although dental personnel primarily treat the area in and around your mouth, it is important that we consider your medical history, current health and medications when providing your dental treatment. Thank you for answering the following questions.

PATIENT'S NAME ____________________ DATE OF BIRTH ____________

1. Have you been under the care of a Medical Doctor in the past two years? ☐ Yes ☐ No
   If Yes, for what? ____________________
   PHYSICIAN NAME ____________________
   ADDRESS ____________________
   PHONE ____________________
2. List any medications you are currently taking or have taken in the past two years ____________________
3. Have you been hospitalized in the past five years? ☐Yes ☐No If Yes, for what? ____________________
4. Circle any of the following that you are allergic to or have had reactions to:
   Local anesthetics like Novocaine Penicillin or other antibiotics — Aspirin Sulfa Drugs Iodine Latex
   Other ____________________
5. Have you ever had any excessive bleeding requiring special treatment? ☐ Yes ☐No If Yes, for what? ____________________
6. Do you experience shortness of breath? ☐ Yes ☐ No
   When? ____________________
7. Are you on a special diet? ☐ Yes ☐No
   Type of diet? ____________________
8. Has your doctor ever advised you to take antibiotics for dental treatment? ☐ Yes ☐ No
9. Do you use tobacco? ☐ Yes ☐ No
10. Do you use alcohol? ☐ Yes ☐ No
11. Do you use cocaine? ☐ Yes ☐ No
    Cocaine is not compatible with nitrous oxide. If taken together, they can be fatal.
12. Women: Are you pregnant? ☐ Yes ☐ No
    Are you taking birth control? ☐ Yes ☐ No

Circle any of the following you have had or have currently

Heart defect or heart murmur
Rheumatic Heart disease or fever
Congenital Heart Lesions
Artificial Heart Valve
Artificial Joints or implants
Blood Transfusion
Drug Addiction
Heart Disease/Heart Attach/Angina
Pacemaker
High Blood Pressure
Heart Surgery
Low Blood Pressure
Cortisone Medicine
Glaucoma
Bruise Easily
Anemia
Emphysema
Persistent cough
Tuberculosis
Asthma or Hay Fever
Mitral Valve Prolapse
Valvular Heart Infection
Diabetes or Hypoglycemia
Thyroid Problems
X-Ray/Cobalt Treatment
Chemotherapy
Arthritis or Rheumatism
Fainting or Dizzy Spells
Nervousness
Psychiatric Treatment
Sickle Cell Disease
AIDS/HIV
Hepatitis A (Infectious)
Hepatitis B (Serum)
Liver Disease or Jaundice
Sinus Trouble
Allergies/Hives or Skin Rash
Hemophilia
Sexually Transmitted Disease
Cold Sores
Genital Herpes
Epilepsy or Seizures
Stroke
Kidney Trouble
Ulcers
Abnormal Bleeding

Do you have any problem, disease or condition not listed above? ____________________

Date of last physical examination ____________________

I certify the above information is complete and accurate to the best of my knowledge. I also understand that this information will be held in the strictest confidence (see attachment).

PATIENTS SIGNATURE ____________________ DATE ____________

DOCTORS SIGNATURE ____________________ DATE ____________

Rick R. Dayton, D.D.S.

Patient Acknowledgement and Consent Form

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPPA") requires this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.
To comply with one of HIPPA's requirements, we are giving you a copy of our Notice Privacy Practices. This Notice of Privacy Practice contains the information that HIPPA requires us to disclose regarding our privacy practices.
Existing Michigan Law requires (in addition to our attempt to obtain your written acknowledgment, discussed above) us to first obtain your written consent prior to disclosing any of your information except for our disclosures in connect with: a defense to a claim challenging our professional competence; a review entity's functions; a claim for payment of fees; a third party payer's examination of our records; a court order as part of a criminal investigation. From time to time it may be necessary for us to make disclosures of your information in connect with your treatment. For example, we may make a referral to or consult with another dentist or other health care professional, provide a specimen to a laboratory for testing otherwise make disclosure of your information in connection with providing or coordinating you treatment.

Patient Acknowledgment

Please sign this form below under the heading "acknowledgment" to acknowledge that you have today received a copy of our notice of privacy protection.

I acknowledge that I have today received a copy of the Notice of Privacy Practices.

____________________________ ____________________________

Patient Signature **Patient Name (Please Print)**

____

Date

Patient Consent

Please sign this form below under the heading "Consent" to consent to our disclosure of your information that we deem necessary in order to proved you with proper treatment.

I consent to your disclosures of my information, which you deem are necessary in connection with my treatment. I understand that such disclosure may not be of the type listed above.

____________________________ ____________________________

Patient Signature **Patient Name (Please Print)**

____

Date

For office use only

Patient Refused to Sign ☐
Communication barriers are prohibited obtaining the acknowledgment ☐
An emergency situation prevented us from obtaining acknowledgment ☐
Other (please specify) ☐

____

____

Office Personnel (Signature) Date Office Personnel (Print Name)