Patient Registration

First Name_____ Last Name_____ Middle Initial _____

Preferred Name _____

Patient Information

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell _____ Work _____

Sex: ___ M ____F Marital Status ___ Single ___ Married ___Divorced___ Separated____ Widowed___

Date of Birth_____ Age_____ Social Security _____ Drivers License_____

Email _____ Would you like to receive correspondences via email? Y or N

Responsible Party (if someone other than patient)

First Name_____ Last Name_____ Middle Initial _____

Address:_____

_____ City_____ State_____ Zip _____

Home Phone_____ Cell Phone _____ Work Phone _____

Date of Birth _____ Social Security _____ Drivers License _____

___ Responsible Party is also Policy Holder for patient

Insurance Information

Policy Holder Name _____Relationship to Policy Holder __Self__Spouse__Child__Other

Policy Holder Social Security _____Policy Holder Date of Birth _____

Employer _____ Insurance Company Name _____

Member/ID Number _____ Group Number_____

Group Name_____

Medical History Form

Patient Name: ..

Date of Birth:

Sex:

Emergency Contact _____

Emergency Contact Phone _____

Emergency Contact Relationship _____

Do you have any of the following diseases or problems

Active Tuberculosis ..... Yes No

Persistent cough greater than a 3 week duration ..... Yes No

Cough that produces blood ..... Yes No

Been exposed to anyone with tuberculosis ..... Yes No

Medical History

Are you now under the care of a physician? ..... Yes No

Physician Name _____

Phone (including area code) _____

Address/City/State/Zip _____

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

Has there been any change in your general health within the past year? ..... Yes No

If yes, what condition is being treated? _____

Date of last physical exam _____

Have you had a serious illness, operation or been hospitalized in the past 5 years? ..... Yes No

If yes, what was the illness or problem? _____

Are you taking or have you recently taken any prescription or over the counter medicine(s)? ..... Yes No

If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements

_____

Do you wear contact lenses? ..... Yes No

Joint Replacement. Have you had any orthopedic total joint (hip, knee, elbow, finger) replacement? ..... Yes No

Date _____

If yes, have you had any complications? _____

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease? Yes No

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous biphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? Yes No

Date Treatment began _____

Do you use controlled substances (drugs)? ..... Yes No

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

If so, are you interested in stopping? VERY / SOMEWHAT / NOT INTERESTED _____

Do you drink alcoholic beverages? ..... Yes No

If yes, how much alcohol did you drink in the last 24 hours? _____

If yes, how much do you typically drink in a week? _____

WOMEN ONLY. Are you:

Pregnant ..... Yes No

Number of weeks _____

Taking birth control pills or hormonal replacement? ..... Yes No

Nursing? ..... Yes No

Allergies, Are you allergic to or have you had any reaction to

Local anesthetics ..... Yes No

Aspirin ..... Yes No

Penicillin or other antibiotics ..... Yes No

Barbiturates, sedatives, or sleeping pills ..... Yes No

Sulfa drugs ..... Yes No

Codeine or other narcotics ..... Yes No

Metals ..... Yes No

Latex (rubber) ..... Yes No

Iodine ..... Yes No

Hay fever/seasonal ..... Yes No

Animals ..... Yes No

Food ..... Yes No

Other ..... Yes No

If Other, please specify:

_____

Congenital Heart Disease (CHD) - Please indicate if you have had or not had any of the following:

Artificial (prosthetic) heart valve ..... Yes No

Previous infective endocarditis ..... Yes No

Damaged valves in transplanted heart ..... Yes No

Congenital heart disease (CHD) ..... Yes No

Unrepaired, cyanotic CHD ..... Yes No

Repaired (completely) in the last 6 months ..... Yes No

Repaired CHD with residual defects ..... Yes No

Other Diseases and Conditions - Please indicate if you have had or not had any of the following:

Cardiovascular disease ..... Yes No

Angina ..... Yes No

Arteriosclerosis ..... Yes No

Congestive heart failure ..... Yes No

Damaged heart valves ..... Yes No

Heart attack ..... Yes No

Heart murmur ..... Yes No

Low blood pressure ..... Yes No

High blood pressure ..... Yes No

Other congenital heart defects ..... Yes No

Mitral valve prolapse ..... Yes No

Pacemaker ..... Yes No

Rheumatic fever ..... Yes No

Rheumatic heart disease ..... Yes No

Abnormal bleeding ..... Yes No

Anemia ..... Yes No

Blood transfusion ..... Yes No

If yes, date _____

Hemophilia ..... Yes No

AIDS or HIV ..... Yes No

Arthritis ..... Yes No

Autoimmune disease ..... Yes No

Rheumatoid arthritis ..... Yes No

Systemic lupus erythematosus ..... Yes No

Asthma ..... Yes No

Bronchitis ..... Yes No

Emphysema ..... Yes No

Sinus trouble ..... Yes No

Tuberculosis ..... Yes No

Cancer/Chemotherapy/Radiation Treatment ..... Yes No

Chest pain upon exertion ..... Yes No

Chronic pain ..... Yes No

Diabetes Type I or II ..... Yes No

Eating disorder ..... Yes No

Malnutrition ..... Yes No

Gastrointestinal disease ..... Yes No

G.E. Reflux/persistent heartburn ..... Yes No

Thyroid problems ..... Yes No

Stroke ..... Yes No

Glaucoma ..... Yes No

Hepatitis, jaundice or liver disease ..... Yes No

Epilepsy ..... Yes No

Fainting spells or seizures ..... Yes No

Neurological disorders ..... Yes No

If yes, please specify _____

Sleep disorder ..... Yes No

Mental health disorders ..... Yes No

Specify _____

Recurrent infections ..... Yes No

Type of infection _____

Kidney problems ..... Yes No

Night sweats ..... Yes No

Osteoporosis ..... Yes No

Persistent swollen glands in neck ..... Yes No

Severe headaches/migraines ..... Yes No

Severe or rapid weight loss ..... Yes No

Sexually transmitted disease ..... Yes No

Excessive urination ..... Yes No

Premedication

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ..... Yes No

Name of physician or dentist making recommendation (include phone number) _____

Do you have any disease, condition, or problem not listed above that you think I should know about? ..... Yes No

Please explain _____

_____

Signature of Patient/Legal Guardian

VICTUS DENTAL

HIPPA OMNIBUS RULE: PATIENT ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/LIMITED AUTHORIZATION AND RELEASE FORM

You may refuse to sign this acknowledgment and authorization. In refusing, we may not be allowed to process your insurance claims.

Date_____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTORS/FACILITIES IN THE FUTURE.

_____ _____

Please print name of Patient | Please sign for Patient/Guardian of Patient

_____ _____

Legal Representative/Guardian | Relationship of Representative/Guardian

Your comments regarding Acknowledgements or Consents:_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM RECEPTION AREA:

□ First Name Only □ Proper Surname □ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION AND CONSENT TO TREATMENT. (This includes step-parents, grandparents, and any other caretakers who can have access to this patient's records.)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM MY APPOINTMENTS, TREATMENT AND BILLING INFORMATION VIA:

□ Cell Phone □ Text Message □Home Phone

□ Work Phone □ Email □ Any of the Above

I AUTHORIZE INFORMATION ABOUT MY HEALTH BE CONVEYED VIA:

□ Cell Phone □ Text Message □Home Phone

□ Work Phone □ Email □ Any of the Above

I APPROVE BEING CONTACTED ABOUT SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS OR NEW HEALTH INFO ON BEHALF OF THIS HEALTHCARE FACILITY VIA:

□ Cell Phone □ Text Message □Home Phone

□ Work Phone □ Email □ None of the Above (opt out)

In signing this HIPPA Patient Acknowledgement Form, you acknowledge and authorize that this office may recommend products or services to promote your improved health. This office may not receive third party remuneration from these affiliated companies. We, under current HIPPA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only:

As Privacy Officer, I attempted to obtain the patient's (or representatives) signatures of this Acknowledgement but did not because:

____ It was an emergency treatment ____ I could not communicate with the patient ____ The patient refused to sign

____ Other (Please describe) ____ The patient was unable to sign because:

_____

Signature of Privacy Officer

VICTUS DENTAL

FINANCIAL GUIDELINES

ALL PATIENTS UNDER THE AGE OF 18 MUST BE ACCOMPANIED BY A PARENT OR LEGAL GUARDIAN AT EACH APPOINTMENT.

- **We are committed to providing you with the best dental care possible, and we are willing to discuss our professional fees with you at any time.**
- **All patients must complete our "Patient Information Form" before seeing our dentists and all information must be completed.**
- **Our office requires a form of government issued picture ID to be kept on file for all legal guardians and patients over the age of 18.**
- **Payment is due when services are rendered. We accept checks, cash, Visa, MasterCard, Discover, and American Express.**
- **Financing is available through Care Credit. Please feel free to inquire at the front desk.**
- **Please call our office at least 24 hours in advance if you need to change or cannot make your appointment. Failure to do so may result in dismissal from the practice and a possible fee.**

DENTAL INSURANCE

If you have dental insurance, we are willing to assist you in receiving your maximum allowable benefits. We will gladly discuss your treatment plan and any questions relating to your insurance. You must realize that:

1. Your insurance contract is between you, your employer, and the insurance company. We are not a party to that contract. We will inform you if we are a preferred provider for your insurance.
2. Usual and customary rate (UCR) is an insurance term and not a dental term. Our fees are generally considered to fall within the UCR of most insurance. Dentists' are not bound by these fees dictated by any particular insurance company.
3. Not all services are a covered benefit in all contracts. This difference will be described by the insurance in the explanation of benefits (EOB).
4. Predeterminations are never a guarantee of payment from your insurance.
5. **Insurance benefits are only as estimate and based on information given to our office by your insurance company.**

We must emphasize that as a dental health care provider, our relationship is with our patient and not the insurance company. Filing your insurance is a courtesy that we extend to our patients and all fees are the patient's responsibility from the date the service is rendered.

- Returned checks will be subjected to a $25.00 Charge.
- Checks are processed electronically and will be electronically debited from your account in 24 hrs.
- Please allow 24 hours notice for rescheduling appointments to avoid a $25 broken appointment fee.

Thank you for understanding the financial policy. Please let us know if you have any questions or concerns.

Date:_____

Print Name:_____

Patient/Guardian Signature:_____