



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 _____

06/21/2019

Medical History Form

Patient Name: .. Emergency Contact _____
 Date of Birth: Emergency Contact Phone _____
 Sex: 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 <input type="radio"/> Yes <input type="radio"/> No	Iodine <input type="radio"/> Yes <input type="radio"/> No
Aspirin <input type="radio"/> Yes <input type="radio"/> No	Hay fever/seasonal <input type="radio"/> Yes <input type="radio"/> No
Penicillin or other antibiotics <input type="radio"/> Yes <input type="radio"/> No	Animals <input type="radio"/> Yes <input type="radio"/> No
Barbiturates, sedatives, or sleeping pills <input type="radio"/> Yes <input type="radio"/> No	Food <input type="radio"/> Yes <input type="radio"/> No
Sulfa drugs <input type="radio"/> Yes <input type="radio"/> No	Other <input type="radio"/> Yes <input type="radio"/> No
Codeine or other narcotics <input type="radio"/> Yes <input type="radio"/> No	If Other, please specify: _____
Metals <input type="radio"/> Yes <input type="radio"/> No	
Latex (rubber) <input type="radio"/> Yes <input type="radio"/> No	

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

Artificial (prosthetic) heart valve <input type="radio"/> Yes <input type="radio"/> No	Congenital heart disease (CHD) <input type="radio"/> Yes <input type="radio"/> No
Previous infective endocarditis <input type="radio"/> Yes <input type="radio"/> No	Unrepaired, cyanotic CHD <input type="radio"/> Yes <input type="radio"/> No
Damaged valves in transplanted heart <input type="radio"/> Yes <input type="radio"/> No	Repaired (completely) in the last 6 months <input type="radio"/> Yes <input type="radio"/> No
	Repaired CHD with residual defects <input type="radio"/> Yes <input type="radio"/> No

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

Cardiovascular disease <input type="radio"/> Yes <input type="radio"/> No	Anemia <input type="radio"/> Yes <input type="radio"/> No
Angina <input type="radio"/> Yes <input type="radio"/> No	Blood transfusion <input type="radio"/> Yes <input type="radio"/> No
Arteriosclerosis <input type="radio"/> Yes <input type="radio"/> No	If yes, date _____
Congestive heart failure <input type="radio"/> Yes <input type="radio"/> No	Hemophilia <input type="radio"/> Yes <input type="radio"/> No
Damaged heart valves <input type="radio"/> Yes <input type="radio"/> No	AIDS or HIV <input type="radio"/> Yes <input type="radio"/> No
Heart attack <input type="radio"/> Yes <input type="radio"/> No	Arthritis <input type="radio"/> Yes <input type="radio"/> No
Heart murmur <input type="radio"/> Yes <input type="radio"/> No	Autoimmune disease <input type="radio"/> Yes <input type="radio"/> No
Low blood pressure <input type="radio"/> Yes <input type="radio"/> No	Rheumatoid arthritis <input type="radio"/> Yes <input type="radio"/> No
High blood pressure <input type="radio"/> Yes <input type="radio"/> No	Systemic lupus erythematosus <input type="radio"/> Yes <input type="radio"/> No
Other congenital heart defects <input type="radio"/> Yes <input type="radio"/> No	Asthma <input type="radio"/> Yes <input type="radio"/> No
Mitral valve prolapse <input type="radio"/> Yes <input type="radio"/> No	Bronchitis <input type="radio"/> Yes <input type="radio"/> No
Pacemaker <input type="radio"/> Yes <input type="radio"/> No	Emphysema <input type="radio"/> Yes <input type="radio"/> No
Rheumatic fever <input type="radio"/> Yes <input type="radio"/> No	Sinus trouble <input type="radio"/> Yes <input type="radio"/> No
Rheumatic heart disease <input type="radio"/> Yes <input type="radio"/> No	Tuberculosis <input type="radio"/> Yes <input type="radio"/> No
Abnormal bleeding <input type="radio"/> Yes <input type="radio"/> No	Cancer/Chemotherapy/Radiation Treatment <input type="radio"/> Yes <input type="radio"/> No
	Chest pain upon exertion <input type="radio"/> Yes <input type="radio"/> 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

Signature of Patient/Legal Guardian



**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



PEDIATRIC DENTAL CONSENT FORM

Patient's Name: _____

As health professionals, it is necessary that we obtain your consent for oral treatment on your child. Please read this carefully and ask any questions that may not be clear or that you may not understand.

I, _____ authorize Victus Dental to treat my child for the following dental or oral surgery procedures; including the use of oral anesthesia, nitrous oxide, and sedatives or radiographs that may be necessary.

In general terms these procedures include: (Please Initial)

- _____ A. Dental cleaning, fluoride application and radiographs as necessary
- _____ B. Application of sealants to dental fissures
- _____ C. Restoration of broken teeth or fillings
- _____ D. Treatment of infected teeth or gums
- _____ E. Extractions of one or more teeth
- _____ F. Use of analgesia- Nitrous Oxide- due to behavior
- _____ G. Other _____

My child's treatment, alternative methods of treatment, as well as advantages and disadvantages of each have been explained to me. I have been advised that although the best results are expected, there is no way within reason of anticipating complications; therefore it is not possible to guarantee the results or cure the treatment.

Although the occurrence is extremely remote, it is known that some risks are associated with dental procedures. We are required to mention the following: numbness, infection, damage to central nervous system, reduction or loss of function of internal organs and limbs, as well as disfiguring scars.

I understand that certain complications may be fatal or require future medical intervention.

Parent of Guardian Signature

Date

Witness



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: _____