CHRISTINA GREENE
FAMILY DENTISTRY

DENTAL REGISTRATION AND HISTORY

Patient Information

Date_____

Social Security #: _____

Patient Name: _____

First Name Middle Name Last Name

Preferred Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

E-mail Address where you can be reached: _____

Date of Birth: _____ Current Age: _____ Sex: _____

Martial Status: _____

Patient Employer/School: _____

Occupation: _____

Contact Information:

Phone: ( ) _____ Work: ( ) _____ Cell: ( ) _____

Best time and method to reach you? _____

IN CASE OF AN EMERGENCY WHO SHOULD BE CONTACT?

Name: _____ Relationship: _____

Phone Number: _____

How did you hear about our office? _____

Dental Insurance

Who is responsible for this account? _____

Relationship to the Patient: _____

Insurance Company: _____

Group #: _____ Subscribers Name: _____

Subscribers Date of Birth: _____ Subscribers Employer:_____

Subscribers Social Security Number: _____

Assignment and Release: I certify that I and my dependent(s) have insurance coverage with _____ and assign directly to Dr. Greene all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all chargers whether they are paid for by the insurance company or not. I authorize the use of my signature on all insurance submissions. The above named dentist may use my health care information and disclose such information to the above insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature of Patient/Parent/Guardian: _____ Date: _____

Please Print name of Patient/Parent/Guardian: _____ Relationship to Patient: _____

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Health History

Physicians Name: _____ Physicians Phone Number:_____ Date of Last Visit: _____

Please circle a YES or NO to indicate if you have any of the following:

AIDS/HIV	YES	NO	EPILEPSY	YES	NO	RESPIRATORY DISEASE	YES	NO
ANEMIA	YES	NO	FAINTING/DIZZINESS	YES	NO	RHEUMATIC FEVER	YES	NO
ARTHRITIS/RHEUMATISM	YES	NO	GLAUCOMA	YES	NO	RADIATION TREATMENT	YES	NO
ARTIFICIAL HEART VALVES	YES	NO	HEADACHES	YES	NO	SCARLET FEVER	YES	NO
ARTIFICIAL JOINTS	YES	NO	HEART MURMUR	YES	NO	SHORTNESS OF BREATH	YES	NO
ASTHMA	YES	NO	HEART PROBLEMS	YES	NO	SINUS TROUBLE	YES	NO
BACK PROBLEMS	YES	NO	HEPATITIS	YES	NO	SKIN RASH	YES	NO
BLEEDING ABORNAMLITY	YES	NO	HERPES	YES	NO	SPECIAL DIET	YES	NO
BLOOD DISEASE	YES	NO	HIGH BLOOD PRESSURE	YES	NO	STROKE	YES	NO
CANCER	YES	NO	JAUNDICE	YES	NO	SWOLLEN FEET/ANKLES	YES	NO
CHEMICAL DEPENDENCY	YES	NO	JAW PAIN	YES	NO	SWOLLEN NECK GLANDS	YES	NO
CHEMOTHERAPY	YES	NO	KIDNEY DISEASE	YES	NO	THYROID PROBLEMS	YES	NO
CIRCULATORY PROBLEMS	YES	NO	LIVER DISEASE	YES	NO	TONSILLITIS	YES	NO
CONGENITAL HEART DISEASE	YES	NO	LOW BLOOD PRESSURE	YES	NO	TUBERCULOSIS	YES	NO
CORTISONE TREATMENT	YES	NO	MITRAL VALVE PROLAPSE	YES	NO	TUMOR/GROWTH	YES	NO
PERSISTANT COUGH	YES	NO	NERVOUS PROBLEMS	YES	NO	ULCER	YES	NO
DIABETES	YES	NO	PACEMAKER	YES	NO	VENEREAL DISEASE	YES	NO
EMPHYSEMA	YES	NO	PSYCHIATRIC CARE	YES	NO	UNEXPLAINED WEIGHT LOSS	YES	NO

Have you ever used a bisphosphonate (bone strengthening) medication? (Fosamax, Acontel, Atelvia, Boniva, Didronel) ☐YES ☐NO

If you are diabetic, what was your last A1C? _____

Are you on any blood thinners? If so, which one? _____

Has a physician ever told you that you need to take an antibiotic prior to dental treatment? _____

Are you pregnant or think that you may be pregnant? ☐YES ☐NO Are you currently nursing? ☐YES ☐NO

Are you a smoker? ☐YES ☐NO Do you use other any tobacco products? _____

Please mark if you are allergic to any of the following:

☐ASPIRIN ☐ LOCAL ANESTHEIC (LIDOCAINE/SPEOTCAINE) ☐PENICILLIN ☐SLEEPING PILLS ☐LATEX ☐ CODEINE

Please list any other allergies:

_____

_____

Please list all medications that you are currently taking:

_____

_____

_____

Is there any other information that we should know about your medical history?

_____

CHRISTINA GREENE
FAMILY DENTISTRY

Dental Health History

What is the reason for your visit today?

_____

_____

Date of last dental visit _____ Former Dentist: _____ Date of last dental X-rays: _____

What would you say is your overall goal for your teeth?

_____

Are you interested in improving the way your smile looks? _____

How often do you brush? _____ What type of toothbrush do you use? _____How often do you floss? _____

Are you interested in whitening? _____ Do you have any broken or missing teeth? _____

Please mark if you have any of the following problems:

BAD BREATH	☐	FINGERNAIL BITING	☐	BLEEDING GUMS	☐
BLEEDING GUMS	☐	FOOD COLLECTION BETWEEN TEETH	☐	MOUTH BREATHING	☐
BLISTERS ON LIPS/MOUTH	☐	FOREIGN OBJECTS	☐	MOUTH PAIN	☐
BURNING SENSATION ON TONGUE	☐	GRINDING TEETH	☐	ORTHODONTIC TREATMENT	☐
CHEW ON ONE SIDE OF MOUTH	☐	GUMS SWOLLEN/TENDER	☐	PAIN AROUND EAR	☐
CIGARETTE/PIPE/E-CIG SMOKING	☐	JAW PAIN OR TIREDNESS	☐	PERIODONTAL TREATMENT	☐
CLICKING OR POPPING OF JAW	☐	LIP OR CHEEK BITING	☐	SENSITIVITY TO COLD	☐
DRY MOUTH	☐	LOOSE TEETH OR BROKEN FILLINGS	☐	SENITIVITIY TO HOT	☐
SENSITIVITY TO SWEETS	☐	SENSITIVITY TO BITING	☐	SORES OR GROWTHS IN MOUTH	☐

Are there any other dental concerns that you wish to share with the dentist?

_____

Permission for Communication

Christina Greene Family Dentistry would like to contact you via text messaging and e-mail using the information that you provided for appointment reminders. Some limited personal information may be included however no medical or test results will be specified. Please sign below granting us permission to contact you.

Yes I authorize Christina Greene Family Dentistry to contact me via text messaging and e-mail:

Signature: _____ Name Printed: _____ Date: _____

CHRISTINA GREENE
FAMILY DENTISTRY

We are pleased that you have chosen Dr. Christina Greene to satisfy your dental needs. As a courtesy to our patients, we will estimate (based on past experience with each insurance provider) the portion of the fee that will be our patients out of pocket expense. We work hard to make this estimate as accurate as possible, but is it always possible that there may be an additional out of pocket expense after filing with your insurance. The patient portion is due at the time we schedule your appointment. We must emphasize that this is an ESTIMATE only.

Knowing that your concerns lie not only with the treatment of dental problems, but in the cost of such treatment and financial arrangements that can be made, we welcome all your questions now, and at anytime.

We ask that you keep in mind that your insurance benefits are not determined by our office. Insurance benefits are determined by the type of plan chosen by your employer. Since dental services are rendered directly to the patient, you as the patient are ultimately responsible to us for payment. The insurance company, of course, is responsible to you. To avoid disappointment, we strongly suggest that you contact your insurance company to make sure assumptions about your dental coverage correct.

After our office initially files your claim with your company's carrier, we will follow up (providing necessary documentation, x-rays, narrative etc.) for 60 days. After this 60 day wait, we must request payment for the balance from you. As we stated earlier, we file claims as a courtesy to our patients in an effort to help them afford to finance their dental treatment. However, after a prolonged period, we are unable to keep the outstanding insurance balance on our books and in your account. We will be more than happy to assist you in any way we can to see that you get reimbursed from your insurance company. In the event the insurance company overpays on your claims, the amount of overpayment will be applied to your account or refunded to you as you choose.

Payment Options: Cash, Check, Visa, Mastercard, American Express. Financing options through third party lenders.

Please note: Dr. Greene requires the patients payment portion prior to scheduling appointments on doctor time. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

For patients with dental insurance: we are happy to work with your carrier to maximize your benefits and directly bill them for reimbursement for your treatment. We will provide you with an estimate of your dental benefits based on the information given to us by your insurance company. THIS IS NOT A GUARANTEE OF PAYMENT. You are responsible for any portion not paid by your dental insurance.

Appointments: We kindly ask for 48 hours notice for all changes in appointments as a courtesy. Please be advised a charge of $50.00 will be made for broken appointments without a 24 hour notice.

Thank you.

Date: _____

Responsible Party Signature: _____ Printed Name: _____

CHRISTINA GREENE
FAMILY DENTISTRY

Notice of Privacy Policies

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your protected health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 06 / 01 / 2011 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and provide the new Notice at our practice location, and we will distribute it upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this notice.

Your Authorization: In addition to our use of your health information for the following purposes, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

Uses and Disclosures of Health Information

We use and disclose health information about you without authorization for the following purposes.

Treatment: We may use or disclose your health information for your treatment. For example, we may disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

To You Or Your Personal Representative: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to your personal representative, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your absence or incapacity or in emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Disaster Relief: We may use or disclose your health information to assist in disaster relief efforts.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Public Health and Public Benefit: We may use or disclose your health information to report abuse, neglect, or domestic violence; to report disease, injury, and vital statistics; to report certain information to the Food and Drug Administration (FDA); to alert someone who may be at risk of contracting or spreading a disease; for health oversight activities; for certain judicial and administrative proceedings; for certain law enforcement purposes; to avert a serious threat to health or safety; and to comply with workers' compensation or similar programs.

Decedents: We may disclose health information about a decedent as authorized or required by law.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying. If you request copies, we will charge you $25 to cover staff time needed to copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations, and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. In most cases we are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in certain circumstances where disclosure is required or permitted, such as an emergency, for public health activities, or when disclosure is required by law). We must comply with a request to restrict the disclosure of protected health information to a health plan for purposes of carrying out payment or health care operations (as defined by HIPAA) if the protected health information pertains solely to a health care item or service for which we have been paid out of pocket in full.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: You may receive a paper copy of this notice upon request, even if you have agreed to receive this notice electronically on our Web site or by electronic mail (e-mail).

CHRISTINA GREENE
FAMILY DENTISTRY

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us. .

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Acknowledgement of Receipt of Notice of Privacy Practices

* You May Refuse to Sign This Acknowledgment*

I, _____, have received a copy of this office's Notice of Privacy Practices. By signing below, I am acknowledging that: I am either the patient or patients personal representative. I understand that I may contact the person named in the Notice if I have questions about the content of the Notice.

Print Name _____

Signature _____ Date _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)_____

Signature: _____

CHRISTINA GREENE
FAMILY DENTISTRY

PATIENT PHOTOGRAPHY RELEASE AND CONSENT

I, _____, hereby authorize the doctors, staff and representatives of Christina Greene Family Dentistry to take photographs, slides, and/or videos (hereafter referred to as "images") of my or my child's (name: _____) face, jaws, mouth, and teeth.

I approve of these images being used as a record of my or my child's care; for teaching purposes, advertising and marketing materials; and on the Christina Greene Family Dentistry website.

I understand that these images may be cropped or altered, and that my or my child's name or other identifying information will be kept confidential.

I understand that once the image is posted on the Christina Greene Family Dentistry website, the image can be downloaded by any computer user. I will hold Christina Greene Family Dentistry, the doctors, staff and its representatives harmless from any such use or download.

I expect no compensation, financial or otherwise, for the use of these images.

I understand that I may revoke or withdraw this consent at any time. Such withdrawal of consent must be made in writing. Withdrawal of consent does not affect any information disclosed prior to the written notice of withdrawal.

I hereby release and hold harmless Christina Greene Family Dentistry, its doctors, its staff, its contractors and any third parties involved in the creation or publication of print materials or the websites, from liability for any and all claims, actions and liability by me or any third party in connection with the use of these images.

_____
Patient Name (print)

_____
Patient Signature (or parent/legal guardian if patient is under 21 years of age)

Date _____