# PATIENT REGISTRATION

Dr. Richard A. Peyser, DDS, P.C. & Dr. Brian D. Peyser, DDS
Family & Cosmetic Dentistry

## Patient Information

Patient Name:_____Date:_____
Last First MI (*Preferred Name)*

__ Male __Female __Married __Single __Child __Other_____

Social Security #: _____ Birth Date:_____

Home Phone #:_____Cell #:_____Work #:_____

Home Address:_____
Street Apartment #

_____
City State Zip Code

Email:_____ Employer:_____Occupation:_____

Whom may we thank for referring you to our practice? __Another patient __Co-worker/employer __Insurance directory

Name of the person referring you to our practice:_____

## Dental & Health History

Reason for today's visit:_____

Date and reason of last dental visit:_____

Date of last dental cleaning:_____Date of last dental x-rays:_____

Have you ever had any complications following dental treatment? __Yes __No

If yes, please explain:_____

How often do you brush ***per day***?_____ How often do you floss ***per week?***_____

Have you ever been diagnosed with gum disease or seen a periodontist (gum specialist)? __Yes __No

Have you had orthodontic work (braces) __Yes __No

Have you had wisdom teeth extracted? __Yes __No

Do you smoke or use smokeless tobacco? __ Yes __No If yes, how much per day?_____

If female, are you pregnant? __ Yes __No If yes, due date?_____

Do you have an allergic reaction to any of the following? ….....__Yes __ No

(If yes, please circle below)

__Aspirin __Codeine __Latex __Metal __Penicillin __Sulfa __Other_____

Have you had or ever been told you have:

| | | | |
|---|---|---|---|
| *A reaction to an anesthetic injection?* | __Yes __No | *Heart murmur, mitral valve prolapse or rheumatic fever*? | __Yes _No |
| *Pacemaker, stroke?* | __Yes __No | *Artificial joints/replacements?* | __Yes _No |
| *High blood pressure?* | __Yes __No | *Hepatitis, kidney, or liver disease?* | __Yes _No |
| *Diabetes?* | __Yes __No | *Venereal disease?* | __Yes _No |
| *Excessive or prolonged bleeding?* | __Yes __No | *Nervous or mental disorder?* | __Yes _No |
| *Tested HIV positive?* | __Yes __No | *Difficulty getting numb?* | __Yes _No |
| *Cancer?* | __Yes __No | *Thyroid disease (Hyper/Hypo)?* | __Yes _No |

Please list any medications you are currently taking:_____

_____

_____

Please identify any additional information about your health that we should know about:_____

_____

_____

## Notice of Privacy Practices

*This notice describes how medical information about you may be used and disclosed and how you can get access to this information. For a complete description of the notice, please see the front desk.*

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1966 (HIPAA). I understand that by signing this consent I authorize Dr's Peyser, DDS, PC and its employees to use and disclose my protected health information to carry out:

- Treating (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers ( e.g. my insurance company);
- The day-to-day healthcare operations of the dental practice.

I have also been informed of, and given the right to review and secure a copy of the *Notice of Privacy Practices,* which contains a more complete description of the uses and disclosures of my protected health information, and my rights under

HIPAA. I understand that Dr's Peyser, DDS, PC, reserves the right to change the terms of this notice from time to time and that I may contact the office at any time to obtain the most current copy of this notice.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

_____

Signature of Patient/Guardian Date

_____

Printed Name Relationship to Patient

__ No Insurance (*if applies, go to page 4*)

## Insurance Information

Insurance Plan:_____ Group #:_____
Subscriber's Name:_____ SSN/Member ID #:_____
Last First MI
Subscriber's Birth Date:_____Phone (Home):_____ (Cell/Other):_____

Subscriber's Address:_____
Street City State Zip code
Subscriber's Employer:_____Phone:_____

Employer's Address:_____
Street City State Zip code
Patient's relationship to subscriber: __ Self __Spouse __ Child __Other Is subscriber a patient? __Yes __No

***If you have additional insurance, please complete the following:***

Insurance Plan:_____ Group #:_____
Subscriber's Name:_____ SSN/Member ID #:_____
Last First MI
Subscriber's Birth Date:_____Phone (Home):_____ (Cell/Other):_____

Subscriber's Address:_____
Street City State Zip code
Subscriber's Employer:_____Phone:_____

*Additional insurance information cont..*

Employer's Address:_____
Street City State Zip code
Patient's relationship to subscriber: __ Self __Spouse __ Child __Other Is subscriber a patient? __Yes __No

## Emergency Contact

Emergency Contact Name:_____

Relationship to Patient:_____

Phone (Home):_____Work:_____ Cell/Other:_____

## Patient Consent

*Please read carefully review and initial each statement.*

_____To the best of my knowledge, the information I have provided regarding my health are true and correct. If I have any changes in my health, I understand it is my responsibility to inform Dr's Peyser and their staff.

_____ I authorize Dr's Peyser and their staff to release any information concerning my health care and for the treatment purpose of evaluating and administering claims for insurance benefits. I further authorize and assign payment of insurance benefits directly to the practice of Dr. Richard A. Peyser, DDS, PC and Dr. Brian D. Peyser DDS.

_____I agree to pay the total cost of my treatment at the time of services are performed, unless previous financial arrangements have been made. If I have insurance, I agree to pay my estimated co-payment at the time of service and any remaining balance that is not paid by my insurance carrier.

_____ I agree to pay a missed appointment fee if I fail to show up for my appointment, or if I fail to give a minimum **one full business day notice** appointment cancellations. Furthermore, I understand that a pattern of missed appointments may result in dismissal from the office.

I have read the above statements and agree to the terms and content in its entirety. If I am not the responsible party on this account, my signature below represents consent on behalf of the responsible party.

_____

Signature of Patient or Responsible Party Date

_____

Printed Name Relationship to Patient