Barbara L Billings

Confidential Child Registration

Today's Date_____

PATIENT'S NAME LAST | FIRST | MIDDLE | NICKNAME | DATE OF BIRTH | SEX

PATIENT'S ADDRESS STREET | APT# | CITY | STATE | ZIP | HOME PHONE

HOBBIES/SPORTS | PREVIOUS DENTIST

WHO IS RESPONSIBLE FOR MAKING APPOINTMENTS?

NAME | RELATION | WORK # | PHONE #

PARENT INFORMATION WHO IS ACCOMANYING YOU TODAY?

NAME | RELATION | WORK # | PHONE #

DOES THIS PERSON HAVE LEGAL CUSTODY? Y N

PARENT'S MARITAL STATUS ☐SINGLE ☐MARRIED ☐WIDOWED ☐REMARRIED ☐DIVORCED ☐SEPARATED

MOTHER'S INFORMATION: ☐ STEP MOTHER ☐GUARDIAN

WORK # | HOME # | NAME_____BIRTHDAY_____

EMPLOYER | HOW LONG AT CURRENT JOB?

FATHER'S INFORMATION: ☐ STEP FATHER ☐GUARDIAN

WORK # | HOME # | NAME_____BIRTHDAY_____

EMPLOYER | HOW LONG AT CURRENT JOB?

PERSON RESPONSIBLE FOR ACCOUNT

NAME | RELATION | EMPLOYER | SSN

BILLING ADDRESS

EMERGENCY PERSON WE CAN CONTACT (OTHER THAN YOUR FAMILY HOME)

NAME | WORK PHONE | HOME PHONE

NAMES OF OTHER FAMILY MEMBERS THAT ARE PATIENTS HERE | WHO CAN WE THANK FOR REFERRING YOU TO OUR OFFICE

PRIMARY DENTAL INSURANCE

Name(Policy Holder)_____
S.S.#_____-____-_____ or ID#_____
Date of Birth_____/_____/_____
Employer_____
Insurance Company_____
Address_____
City_____State___Zip_____
Phone #_____-_____-_____
Group #_____
Patients Relationship to Insured
Self___Spouse___Child___Other_____

SECONDARY DENTAL INSURANCE

Name(Policy Holder)_____
S.S.#_____-____-_____ or ID#_____
Date of Birth_____/_____/_____
Employer_____
Insurance Company_____
Address_____
City_____State___Zip_____
Phone #_____-_____-_____
Group #_____
Patients Relationship to Insured
Self___Spouse___Child___Other_____

AUTHORIZATION

I authorize Dr. Barbara L Billings and my physician(s) to release any and all medical or dental information for evaluation, treatment, and any anticipated care. I also authorize the release of this information to my insurance carrier(s) for the purposes of claims, administration, evaluation, utilization review and financial audit. This authorization remains valid and effective from the signature date until revoked in writing. I hereby authorize payment to the above named dentist of the group insurance benefits otherwise payable to me, but not to exceed the charges submitted. **I understand that I am financially responsible for any and all charges (including collection fees);** and that I am responsible for knowledge of my insurance program and its limitations. This office is not responsible for knowing my insurance benefits and limitations. Interest accrues 90 days after services are rendered. I understand that I may request a copy of this form. I have read this authorization and understand its contents. *I also understand that this form will need to be updated every 2 years.*

Please keep in mind, to avoid any cancellation fee, we do require two working days (Mon-Thu) notice for any scheduling changes.

Signed_____Date_____/_____/_____

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No _____
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics
☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pace Maker ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No	Yellow Jaundice ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No	

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Consent for Dental Treatment for your Child

Please indicate any special concern or provide additional information, which you think may be useful in providing dental care of your child.

_____

_____

In case of Emergency contact: (other than parents of child) _____

Relationship to child: _____

Home phone #_____ Cell #_____

1. The undersigned hereby authorizes the doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make thorough diagnosis of the patient's dental needs.
2. I also authorize the doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment. In addition, I understand that using anesthetic agents embodies a certain risk.
3. Futhermore, I authorize and consent that the doctor choose and employ such assistance as deemed fit to provide recommended treatment. If any treatment should vary from that being contemplated, and if there is no reasonable opportunity for additional explanation and authorization, the parent or guardian further authorizes Dr. Billings to proceed with such treatment she considers advisable based on her opinion and judgment.
4. In Dentistry as in all other healthcare treatment, there can be no guarantees of particular outcomes. The cooperation, individual physical and psychological differences and number of other factors.

PATIENT'S NAME_____

_____

Parent or guardian signature **Date** **Signature from Dr. Billings office**

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Dr. Billings keeps a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge that I have been informed of the Notice of Privacy Practices.

_____ _____

Patient or legally authorized individual signature Date

_____

Printed Name if signed on behalf of the patient Relationship