Pacific Hills Dental

New Patient Registration

Welcome to Pacific Hills Dental! At our office, you will find the best in dental care, from our highly skilled staff to the latest in dental technology. Please complete the form below so we can begin to get to know you.

Name: _____
First Middle Initial Last

Date of Birth: _____ Social Security Number: _____

Name of Responsible Party (if patient is a Minor):_____

Address: _____
Street Apt

_____
City State Zip

Phone:_____
Home Work Mobile

What is the best number and time of day to contact you? _____

Drivers License: _____ Email Address: _____

Who can we thank for referring you to us? _____

Insurance Information

Name of Insured Person: _____ Insured's Date of Birth: _____

Employer: _____Name of Insurance Company: _____

Group Number: _____ Participant Number: _____
May be the Insured's Social Security Number

Secondary Insurance: _____

Emergency Contact Information

Name: _____
First Middle Initial Last (Relationship)

Phone: _____ _____ _____
Home Work Mobile

Pacific Hills Dental

Dental History

Are you dissatisfied with the appearance of your teeth? Yes □ No □
Have you had orthodontic treatment? Yes □ No □
Do you clench or grind your teeth at night? Yes □ No □
Have you ever had pain in your jaw? Yes □ No □
Do you have an unpleasant taste or odor in your mouth? Yes □ No □
Do your gums bleed when brushing? Yes □ No □
Have you ever had gum disease or periodontal disease? Yes □ No □
Is your mouth sensitive to hot or cold? Yes □ No □
Do any of your teeth hurt when you bite? Yes □ No □

When was the last time you were seen by a dentist? _____

When was your last dental cleaning appointment? _____

Have you had a full set of x-rays or panoramic x-ray in the last 3 years? Yes □ No □

If yes, when and where? _____

Do you require pre-medication with an antibiotic? Yes □ No □

Home Care and Habits

How often do you brush your teeth? _____

How often do you floss? _____

Do you use mouthwash? Yes □ No □ If so, what kind? _____

Do you have an electric toothbrush? Yes □ No □

Do you snack often between meals? Yes □ No □
If so, what kind of snacks and how often? _____

Do you drink sweetened beverages? Yes □ No □
If so, what kind and how much per day? _____

Have you ever smoked? Yes □ No □
If so, do you still smoke? Yes □ No □

If yes, how much per day? _____

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 _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ 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 ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ 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	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

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 _____

Pacific Hills Dental

Client Rights and HIPAA Authorization

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996 as amended from time to time ("HIPAA"). These Policies & Procedures address the basics of HIPAA and the Privacy Rules that apply in our dental practice. They do not attempt to cover everything in the Privacy Rules. The Policies & Procedures sometimes refer to forms we use to help implement the policies and to the Privacy Rules themselves when added detail may be needed.

1. Tell your provider if you do not understand this authorization and the provider will explain it to you.
2. We are required to provide to you a copy of our HIPAA policies and privacy rules if requested.
3. You have the right to revoke or cancel this authorization at any time, except (a) to the extent information has already been shared based on this Pacific Hills Dental authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage To revoke or cancel this authorization, you must submit your request in writing to provider at the following address: Pacific Hills Dental, 12021 Shamrock Plaza, Omaha, NE 68154.
4. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, payment, enrollment or your eligibility for benefits. However, you may be required to complete this authorization form before receiving treatment if you have authorized your provider to disclose information about you to a third party (i.e. insurance provider). If you refuse to sign this authorization and you have authorized your provider to disclose information about you to a third party (i.e. insurance provider), your provider has the right to decide or not to treat you or accept you as a patient in their practice.
5. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the third party. You need to be aware that at that point your information may no longer be protected by HIPAA. If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.
6. You may inspect or copy the protected dental information to be used or disclosed under this authorization. You do not have the right of access to the following protected dental information: psychotherapy notes, information compiled for legal proceedings, laboratory results to which the Clinical Laboratory Improvement Act (CLIA) prohibits access, or believes access could cause harm to you or another individual. If access is denied, you may request to have a licensed health care professional for a second opinion at your expense.
7. You have the right to an accounting of the disclosures of our protected dental information by provider of its business associates. The maximum disclosure accounting period is the six years immediately preceding the accounting request. The provider is not required to provide an accounting for disclosures: (a) for treatment, payment, or dental care operations; (b) to you or your personal representative; (c) for notification of or to persons involved in a individual's dental care or payment for dental care, for disaster relief, of for facility directories; (d) pursuant to an authorization; (e) of a limited data set; (f) for national security or intelligence purposes; (g) to correctional institutions or law enforcement officials for certain purposes regarding inmates or individuals in lawful custody; or (h) incident to otherwise permitted or required used or disclosures. Accounting for disclosures to dental oversight agencies and law enforcement officials must be temporarily suspended on their written representation that an accounting would likely impede their activities.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

_____

Signed Date

Pacific Hills Dental

Permit to Treat

This is to certify that I, _____ consent to the performing of the dental and oral surgical procedures agreed to be necessary of advisable, including the use of local anesthetics, and I will assume responsibility for fees associated with those procedures.

The information included in the health history is accurate to the best of my knowledge.

_____

Signature Date

Pacific Hills Dental

Permit to treat, responsible party:

This is to certify that I, _____, for _____ consent to the performing of the dental and oral surgical procedures agreed to be necessary of advisable, including the use of local anesthetics as indicated, and I will assume responsibility for fees associated with those procedures.

The information included in this health history is accurate to the best of my knowledge.

_____

Signature: Date:

Pacific Hills Dental

Signature on File /Financial Responsibility

I, _____ authorize Pacific Hills Dental P.C. to file insurance claims on my behalf. I as the patient (responsible party) take full responsibility for my entire account balance.

Payment is due at the time of treatment. We accept cash, check, Discover, Visa, and MasterCard. We also have a payment plan called Care Credit that allows you to start treatment today and spread payments out over time.

I understand that that prior-authorization submitted to my insurance company is not a guarantee of payment but an estimate of benefits payable.

I understand that my dental insurance is a policy between me and the insurance company and that if there is a problem with a benefit that I am responsible to contact my insurance carrier.

If my insurance does not make payment in full to Pacific Hills Dental P.C. within 20 days I am responsible for the entire balance at that time. (Insurance usually pays within 7 to 10 days.)

All accounts past due will be charged a service charge of 16% APR

Signature of Patient (Responsible Party)

_____ _____

Signature: Date: