PEARL RIVER
Family Dentistry

REGISTRATION FORM
(Please Print)

PATIENT INFORMATION

Patient's last name:	First:	Middle:	Marital status (circle one): Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Sex: ❑ Male ❑ Female

Home address:	Social Security no.:	Home phone no.: ( )
	Email Address:	Cell phone no: ( )

P.O. Box:	City:	State:	ZIP Code:
Occupation:	Employer:		Employer phone no.: ( )

INSURANCE INFORMATION

(Please give your insurance card and drivers' license to the receptionist.)

Primary Insurance:

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Secondary insurance (if applicable):	Subscriber's name:	Subscriber's S.S no.:	Birth date:
Group no.:	Policy no.:		

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

1) Name of local friend or relative:	Relationship to patient:	Home phone no.: ( )	Cell phone no.: ( )
2) Name of local friend or relative:	Relationship to patient:	Home phone no.: ( )	Cell phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Pearl River Family Dentistry or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

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Patient Name: _____ Date of Birth: _____ Today's Date: _____

Are you currently under the care of other medical specialists? Please list name and reason including your primary physician. [ ] YES or [ ] NO If yes: _____

Have you ever been hospitalized or had a major operation? [ ] YES or [ ] NO If yes: _____

Have you ever had a serious head/neck Injury? [ ] YES or [ ] NO If yes: _____

Are you currently taking any medications? [ ] YES or [ ] NO If yes: _____

Do you take, or have you taken, Phen-Fen Or Redux? [ ] YES or [ ] NO If yes: _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications Containing bisphosphonates? [ ] YES or [ ] NO If yes: _____

Are you on a special diet? [ ] YES or [ ] NO If yes: _____

Do you use tobacco? [ ] YES or [ ] NO If yes: _____

Do you use controlled substances? [ ] YES or [ ] NO If yes: _____

Pharmacy Name: _____ **City, State:** _____ **Phone Number:** _____

FOR WOMEN ONLY: Are you...

[ ] Pregnant [ ] Trying to get pregnant [ ] Nursing [ ] Oral Contraceptives [ ] NONE

Are you allergic to any of the following?

[ ] Aspirin [ ] Penicillin [ ] Codeine [ ] Acrylic [ ] Metal [ ] Latex [ ] Sulfa Drugs [ ] Local Anesthetics Other? _____

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 Problems	○ 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 that is not listed above? [ ] YES or [ ] NO If yes: _____.

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 HEALTH. IT IS MY RESPONSIBILITY TO INFORM PEARL RIVER FAMILY DENTISTRY OF ANY CHANGES IN MY MEDICAL STATUS.

Patient/Guardian (SIGNATURE): _____ Date: _____

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Missed Appointment and Cancellation Policy

We strive to render excellent dental care to you and the rest of our patients. In an attempt to be consistent with this, we have an Appointment Cancellation Policy that allows us to schedule appointments for all patients. When an appointment is scheduled, that time has been set aside for you and when it is missed, that time cannot be used to treat another patient.

Our policy is as follows:

We require that you give our office 48 hours in the event that you need to reschedule your appointment. This allows for other patients to be scheduled into that appointment. If you miss an appointment without contacting our office within the required time, this is considered a missed appointment. **A fee of $75.00 will be billed to you; this fee cannot be billed to your insurance company and will be your direct responsibility. No future appointments can be scheduled nor can records be transferred without the payment of this fee.**

Additionally, to reserve your scheduled appointment, we kindly require verbal or text confirmation. If we do not receive confirmation, the appointment may be cancelled and offered to another patient on our waiting list.

We thank you in advance for your cooperation.

I have read and understand the above policy. [ ] please initial.

_____ _____

Patient/Guardian Signature Date

_____ _____

Staff Signature Date

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ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

Acknowledgement

I, _____, hereby acknowledge that I have received and reviewed a copy of **Pearl River Family Dentistry's** *HIPAA Notice of Privacy Practices.*

I understand that **Pearl River Family Dentistry's** *HIPAA Notice of Privacy Practices* may change periodically and that I am entitled to receive a copy of **Pearl River Family Dentistry's** revised *HIPAA Notice of Privacy Practices* upon request.

I understand that, if I have questions about **Pearl River Family Dentistry's** *HIPAA Notice of Privacy Practices*, I may contact Dr. Shahnam A. Shifteh or a staff member.

I understand that it is my right to refuse to sign this Acknowledgement should I so choose, and that Pearl **River Family Dentistry** will not refuse treatment to me if I refuse to sign this Acknowledgement.

I further understand that I may contact the Secretary of the U.S. Department of Health and Human Services should I have concerns regarding **Pearl River Family Dentistry's** privacy policies and procedures. For information please to contact the U.S. Department of Health and Human Services.

_____ _____
Patient/Guardian (Print) Date

_____ _____
Patient/Guardian (Signature) Date

I, _____, direct my dental services providers and payers to disclose and release my protected health information described below to:

Name: _____ Relationship: _____

Phone Number: _____ Date: _____

IF YOU DO NOT WISH TO LIST ANYONE, PLEASE CHECK HERE ☐

FOR OFFICE USE ONLY

Pearl River Family Dentistry made a good-faith effort to obtain Acknowledgement, from the patient noted above, of receipt of its *HIPAA Notice of Privacy Practices.* In spite of these efforts, **Pearl River Family Dentistry** was unable to obtain a signed Acknowledgement for the following reason(s):

- ☐ Refusal to sign Acknowledgement on _____, 20_____.
- ☐ Communications barriers prohibited us from obtaining a signed Acknowledgement.
- ☐ An emergency situation prohibited us from obtaining a signed Acknowledgement.
- ☐ Other (Describe):_____