Fairbanks Family Dental Care Inc.
John Brady
Todd S. Christensen

Patient Registration Form

Patient Name: _____Preferred Name_____
SS#(Required for insurance): _____License Number:_____
MailingAddress_____City_____State_____Zip____
Home Phone (____) _____ Mobile (____) _____
Email address:_____
DOB (Required for insurance): _____/_____/_____Sex: Male ☐ Female ☐
Status: Married___ Single ___Other_____
Spouse Name: _____ Phone Number: _____
Employer_____
Work Phone (___) _____
Work Physical Address _____
Emergency Contact Information
Name (last) _____ (first) _____ (mi)_____
Home Phone (__) _____Mobile (__) _____Work(__)_____
How did you hear about Fairbanks Family Dental Care Inc.?
_____
Other Family members seen by us:_____

Parent/Guardian (if patient is a minor):

Name: _____ Relationship to Patient: _____
Home #:_____Work #:_____
Address: _____City:_____State:_____Zip:_____

Dental Insurance Information

Primary Insurance
Insurance Company Name _____ID Number_____
Group Number_____
Subscriber Name _____DOB_____S.S_____
Relation to patient _____

Secondary Insurance
** Please let us know ahead of time which insurance is primary and which one is secondary**
Insurance Company Name _____ID Number_____
Group Number_____
Subscriber Name _____DOB_____S.S_____
Relation to patient _____

Medical History

What is you general state of health? Excellent _____Good _____Fair _____Poor_____
Have you been under constant care of a physician in the last year for an illness? Yes___ No____
If so, then why? _____
Physicians Name_____ Address/Phone Number_____
Have you had any major surgeries in the last 3 years? Yes _____No_____
If so please elaborate _____
_____
** If you need more space please elaborate on the back page **

Do you have any of the following? Check the box to all that apply

☐ AIDs	☐ Fainting	☐ High Blood Pressure	☐ Resp. Problems
☐ Anemia	☐ Excessive Bleeding	☐ Kidney Disease	☐ Rheumatic Fever
☐ Arthritis	☐ Glaucoma	☐ Liver Disease	☐ Sinus problems
☐ Artificial Joints	☐ Hay Fever	☐ Mental Disorders	☐ Tuberculosis
☐ Blood Disorder	☐ Head Injuries	☐ Nervous Disorders	☐ Venereal Disease
☐ Cancer	☐ Heart Disease	☐ Pacemaker	☐ Valve Replacement
☐ Diabetes	☐ Heart Murmur	☐ Pregnant? Due Date _____	
☐ Dizziness	☐ Hep A, B,or C	☐ Radiation Treatment	
☐ Tobacco Use	☐ Recreational Drug		

Any other conditions, disease, or problem's not listed?_____

Drug Allergies:

☐ Latex	☐ Erythromycin	☐ Tetracycline	any not listed
☐ Codeine	☐ Dental Anesthetics	☐ Other	_____
☐ Penicillin	☐ Aspirin		_____

Please list all medications you are taking, including over the counter drugs or herbs:

Medication:	Dosage:	Times/Day

_____
_____

Dental History:

Last dental visit:_____Last Dental Cleaning:_____
Do you have any history of?

☐ Bleeding Gums	☐ Periodontal/Gum Disease
☐ Broken/Chipped Fillings	☐ Tender/Swollen Gums
☐ Cavities	☐ Worn Teeth
☐ Food Traps	☐ Orthodontics
☐ Loose Teeth	If you answered yes, please elaborate below.
☐ Missing Teeth	

_____

Do you have any of the following?

☐ Fixed Bridge	☐ Implants	☐ Loose/ Broken
☐ Full Denture	☐ Removable Partial	☐ Crowns

If so, are you comfortable with them? Yes _____No_____

Consent for services

As a condition of treatment by this office, **all financial arrangements must be made in advance.** The practice depends upon collection from patients for the costs incurred for their care. An estimate of financial responsibility on the part of each patient will be determined before treatment.

All emergency dental services, or any dental services performed without previous arrangements, must be paid for at the time of service.

Any treatment recommendations are made based on what is best for you, our patient; treatment is not recommended based on what will or will not be covered by your insurance. As a courtesy, we will bill your insurance for services rendered. We will do our best to give you an accurate estimation for what will be paid by your dental insurance, but we cannot guarantee what they will pay. **It is our office policy to collect patient's estimated portion at the time of service. If your insurance does not pay because of a lack of benefits or for any other reason they see fit or they do not pay within 90 days the entire account balance will be due and payable by you. Fairbanks Family Dental Care will not be responsible for billing after that time.**

In consideration for the professional services rendered to me by the practice, I agree to pay the charges for the services at the time of treatment.

Signature: _____Date: _____

NOTICE OF PRIVACY PRACTICES

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 health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. The Notice takes effect April 14, 2002, and will remain until we replace it.

We reserve the right to change our privacy practices and terms of the Notice at any time, provided such changes are permitted by applicable law. We will change this Notice and make the new Notice available upon request. You may request a copy of your Notice at any time. You may contact us to request more information about our privacy practices.

USES AND DISCLOSURE OF HEALTH INFORMATION

We use and disclose health information about your for treatment, payment, and healthcare operations. We may use or disclose your health information to a physician or other healthcare providers providing treatment to you. We may use or disclose your health information to obtain payment for services provided to you. We may use or disclose your health information with our healthcare operations. Healthcare operations include assessment and improvement activities, reviewing the competence or qualifications certification, licensing or credentialing activities.

Signature: _____Date: _____

HIPAA COMPLIANCE:

In compliance with the Federal HIPAA policy we are requesting your permission to send out appointment remainders via postcards to the address on file. These postcards will have your name, address, time, and date of the appointment viewable by the post office.

Patient/Guardian Signature: _____Date: _____