TIME 01:51 PM

DATE 2/26/2018

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

Referred By

Previous Dentist

Emergency Contact

Emergency Contact #

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

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, c

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

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

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 not listed above? ◯ Yes ◯ 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 (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:

X

Date: _____

Acknowledgement of Receipt of HIPAA Notice of Privacy Practice

Kosciusko Dental Clinic

500 Veterans Memorial Drive
Kosciusko MS 39090

I, _____, hereby acknowledge that I have received and reviewed a copy of KOSCIUSKO DENTAL CLINIC's *HIPAA Notice of Privacy Practices.*

I understand that KOSCIUSKO DENTAL CLINIC's *HIPAA Notice of Privacy Practices* may change periodically and that I am entitled to receive a copy of KOSCIUSKO DENTAL CLINIC's revised *HIPAA Notice of Privacy Practices* upon request.

I understand that, if I have questions about KOSCIUSKO DENTAL CLINIC's *HIPAA Notice of Privacy Practices*, I may contact Angie Shuler at 662-289-4781.

I understand that it is my right to refuse to sign this Acknowledgement should I so choose, and that KOSCIUSKO DENTAL CLINIIC 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 KOSCIUSKO DENTAL CLINIC's privacy policies and procedures. For information on how to contact the U.S. Department of Health and Human Services, please ask Angie Shuler, noted above, for assistance.

Patient Signature

Date

Signature of Personal Representative

Print Name of Personal Representative

Relationship of Personal Representative to Patient

FOR OFFICE USE ONLY

KOSCIUSKO DENTAL CLINIC 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, KOSCIUSKO DENTAL CLINIC 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):_____

CONSENT FOR EXTRACTION(S) AND ACKNOWLEDGMENT OF RECEIPT OF INFORMATION

We are required by State law to obtain your consent prior to dental treatment. Please ask us about anything you do not understand and we are ready to answer any of your questions or explain anything.

Any alternatives to the recommended treatment, including no treatment, have been explained to me. In general terms the contemplated dental treatment is:

_____EXTRACTION_____

There are risks associated with any dental treatment. This includes the administration of any local or general anesthetic agent, analgesic agent(s) to produce conscious sedation, and/or premedication prior to dental care being rendered. Some of these risks / complications are, but not limited to, the following:

- Allergic reaction to drugs administered, which is unpredictable due to individual differences.

  An infection may result, after an extraction, for unknown reasons.

- In the event a blood clot fails to form, bleeding may occur since each person responds differently to surgery.

- Instruments used in extractions may unavoidably chip or damage adjacent teeth and/or hard or soft tissues.

- Lower teeth and particularly third molars have roots close to the nerve. Occasionally it is impossible to avoid the tooth being extracted from touching, bruising, cutting and in some instances severing the nerve. This may cause paresthesia or numbness of the tongue, and/or chin, mouth, or face. This condition may last for several weeks, months and in some cases indefinitely.

- Occasionally a fracture may result in the surrounding bone adjacent to the extraction site.

- Upper teeth have roots close to the sinus. Occasionally the tooth extracted may have fused to the bone and an opening may result, during the extraction, between the sinus and mouth.

- Occasionally the tooth extracted may have fused to the bone and some loss of bone may occur during the extractions.

- Occasionally boney spicules or fragments may arise at an extraction site. Generally they are easily removed.

- Sometimes the extraction site may fail to heal, since each person is unique and responds differently to surgery.

- Occasionally the blood clot that forms at the extraction site may disintegrate or become dislodged. This may result in a painful condition called DRY SOCKET

that can last for several weeks. Placing medication in the Dry Socket site normally treats this condition. Also, you should avoid chewing food, ice or gum near the area.

- Sometimes it is impossible to extract a tooth without the root of the tooth breaking and being left in the extraction site. Generally this is not a problem but occasionally the fragment becomes infected and must be removed.
- Holding the jaw open during the extraction procedure may cause jaw pain and it may make it difficult opening your mouth for several days.
- Additional oral surgery, hospitalization and/or further treatment may be required in the event of any complication

ACKNOWLEDGMENT

I acknowledge that I have read, or that it has been read to me, and I understand the information contained on this consent form. I was given an adequate opportunity to ask any questions and all questions that were asked, were answered to my satisfaction.

I understand that I am to notify the dentist immediately of any suspected complication(s), where further treatment may be discussed, or administered, which is not currently anticipated.

I hereby authorize and direct the dentist and/or associates, hygienists, assistants of their choice to perform the diagnostic, surgical or dental treatment. This consent will remain valid until revoked by me in writing.

_____

_____

Print Patient's Name
Date

Signature of Patient or Guardian