Patient Registration

Today's Date _____

Last Name_____First Name_____MI_____

Date of Birth_____Age _____

Gender_____ Please Circle One: Single Married Child Other

Mailing Address_____City_____State_____Zip Code _____

Email_____Home Phone (_____)_____Cell Phone (_____)_____

Employer_____Work Phone (_____)_____

If patient is a minor:

Name of Parent_____Date of Birth_____Parent Phone (_____)_____

Parent Address_____City_____State_____Zip_____

Emergency Contact_____Relationship_____Phone # (_____)_____

How did you hear about us?

☐ Social Media ☐ Insurance ☐ Website ☐ Internet ☐ Location/Drive By ☐ Other_____

Who can we thank for your visit? _____

Dental Insurance Information (Primary Carrier)

Subscriber Name _____ _____ _____

Last First MI

Insured's DOB_____Insured's Employer _____

Subscriber's Soc.Sec. # or Alternate Id #_____Group # _____

Insurance Co_____Insurance Phone # _____

Dental Insurance Information Secondary Coverage

Subscriber Name _____ _____ _____

Last First MI

Insured's DOB_____Insured's Employer _____

Subscriber's Soc.Sec. # or Alternate Id #_____Group # _____

Insurance Co_____Insurance Phone # _____

Medical Insurance Information

Insurance Carrier Name _____

Consent for Services

I understand that I am responsible for the cost of the treatment I receive, and that Byce and Worman Family Dentistry submits any of my insurance claims as a courtesy to me, but is not responsible for the payment by my insurance. I will discuss in advance any payment options I may need in order to fulfill my financial obligation.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

I understand that my appointment time has been reserved for me and that failure to give at least 2 business days notice of a cancellation, or a late arrival of 10 minutes or more may result in the office being unable to reschedule me.

I consent Byce and Worman Family Dentistry to take a photo of me to be used during my dental treatment. I understand that this picture is protected by HIPAA and will not be shared or used for any purposes other than facial recognition and smile enhancement.

☐ **I have read the above conditions of treatment and payment and agree to their content.**

Signature of patient, parent, or guardian (responsible party):

Signature_____ Date _____

Relationship to Patient:_____

Medical & Dental History

Cardiovascular
- ☐ Angina (chest pain)
- ☐ Artificial Heart Valve
- ☐ Heart Conditions
- ☐ Heart Surgery
- ☐ High/Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Rheumatic Fever
- ☐ Stroke

Gastrointestinal
- ☐ Ulcers (Stomach)
- ☐ Gastrointestinal Disease

Hematologic/Lymphatic
- ☐ Anemia
- ☐ Blood Disorders
- ☐ Bruise Easily
- ☐ Excessive Bleeding

Neurological
- ☐ Anxiety
- ☐ Depression
- ☐ Dizziness
- ☐ Drug/Alcohol Addiction
- ☐ Fainting
- ☐ Seizures
- ☐ Psychiatric Illness

Medical Allergies
- ☐ Antibiotics (Penicillin/Amoxicillin /Clindamycin)
- ☐ Opioids (Percocet, Oxycodone, Tylenol 3)
- ☐ Latex
- ☐ Local Anesthetics
- ☐ NSAIDs
- ☐ Other Allergies _____

Endocrinology
- ☐ Diabetes
- ☐ Hepatitis A/B/C
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Thyroid Disease

Musculoskeletal
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Jaw Joint Pain
- ☐ Rheumatoid Arthritis

Respiratory
- ☐ Asthma
- ☐ Emphysema
- ☐ Sinus Problems
- ☐ Respiratory Problems
  - Tuberculosis
  - Sleep Apnea

Pre-Medication Required
- ☐ Amoxicillin
- ☐ Clindamycin
- ☐ Other _____

Cancer
Type_____
- ☐ Chemotherapy
- ☐ Radiation Therapy

Viral Infections
- ☐ AIDS
- ☐ HIV Positive
- ☐ HPV

Women
- ☐ Currently Pregnant (Due Date_____)
- ☐ Nursing

Tobacco Use? ☐ Smoking ☐ Chewing If yes how much/often: _____

Have you been hospitalized within the last 5 years due to a surgery or illness? _____

Are you under the care of a physician? Y or N If yes, please explain:

_____

_____

Physician Name_____ Clinic_____
Address_____ Phone (_____)_____

Have you had a serious illness, operation, or hospitalization in the past 5 years? Y or N, If yes please explain:

_____

_____

Are you taking or have you recently taken any prescription or over the counter medicine(s)? Y or N If yes, please list all and why,including vitamins, natural or herbal supplements and/or dietary supplements:

_____

_____

Dental History

Please share the following dates:

Your last cleaning_____/_____Your last complete X-rays_____/_____

Name of your previous dentist_____Phone (_____)_____

☐ **To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next dental appointment without fail.**

Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.
I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.
I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.
I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Signature of patient, parent, or guardian Signature_____ Date _____

Relationship to Patient:_____

Communication Preference

We confirm all appointments in advance via TEXT message.

If you have a conflict, please give us the courtesy of 2 business days notice for cancellations.

Acknowledgments of Receipt of HIPAA Privacy Rights

I,_____have read and understood my rights to privacy regarding the use of my personal health information (PHI). I understand that I may request additional information about this, and may ask more information from the office administrator at any time in accordance with procedural guidelines detailed in the Notice of Privacy Practices Document.

If you would like to provide access to your account to specific individuals, please provide their information below:

_____ _____ Relationship _____
Last First

_____ _____ Relationship _____
Last First

Signature _____ Date _____

Relationship _____

Byce & Worman
FAMILY DENTISTRY

AUTHORIZATION TO RELEASE DENTAL RECORDS

I,_____hereby authorize _____
(Print Patient Name) (Previous Dental Office)

Office Phone Number:_____City/State:_____,_____

to release all my dental radiographs and clinical notes to:

Byce and Worman Family Dentistry

8002 Watts Road
Madison, Wi 53719
info@bwfdental.com
P: 608.831.7770
F: 608.831.7790

Patient Signature:_____Patient DOB:_____/_____/_____

(Parent or Guardian must sign form if patient is a minor.)

Relationship to Patient: _____