TIME:

DATE:

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 #: ________

Confirm by texts?: ________

Primary Insurance Information

Name of Insured: ________ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: ________ Insured Birth Date: ________

Employer: ________

Address: ________

Address 2: ________

City,State,Zip: ________

Ins. Company: ________

Address: ________

Address 2: ________

City,State,Zip: ________

Rem. Benefits: ________.00 Rem. Deduct: ________.00

Secondary Insurance Information

Name of Insured: ________ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: ________ Insured Birth Date: ________

Employer: ________

Address: ________

Address 2: ________

City,State,Zip: ________

Ins. Company: ________

Address: ________

Address 2: ________

City,State,Zip: ________

Rem. Benefits: ________.00 Rem. Deduct: ________.00

Wendy K. Britt, DDS, PLLC

TIME:

DATE:

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?

Condition		Condition		Condition		Condition	
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 ______________

Wendy K. Britt, D.D.S
310 Wilkinson Drive
Laurinburg, NC 28352
910-276-4550 910-276-1157
wkbritt@2thcare4u.com

HIPAA Authorization for Release of Information to Family and/or Friends

Name of Patient ____
Date of Birth _______________

Dr. Wendy K. Britt is authorized to release protected health information about the above named patient to the following listed entities:

ENTITY NAME ______________________________ **RELATIONSHIP** ________________

ENTITY NAME ______________________________ **RELATIONSHIP** ________________

Please initial each situation giving **Dr. Wendy K. Britt** your authorization to supply information to your entity:

_____ Leave information on voice mail
_____ Release financial information
_____ Give information to your adult child (pt is a senior citizen)
_____Give information to spouse
_____Give information to grandparent
______Give information to parent (pt is over 18 yrs of age)
______Discuss Dental Treatment Plan
______Medical information as follows:____
______Other information as described: ____

Please check one of the following (if over 18 years old):

______ I am responsible for my charges
______ __________________________ is responsible for my charges

RIGHTS OF THE PATIENT:

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to **Dr. Wendy K. Britt.** I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing this authorization.

This authorization shall be in force and effect until revoked by the patient or representative signing the authorization.

____ Date ________________
Signature of Patient/Parent/Legal Guardian/Personal Representative

____
Description of Personal Representative's Authority (attach necessary documentation)

Dr. Wendy K. Britt

ACKNOWLEDGEMENT OF RECEIPT OF
HIPAA NOTICE OF PRIVACY PRACTICES
("Acknowledgement")

I acknowledge that I have received a copy of this Dental Practice's **HIPAA Notice of Privacy Practices.**

____
Patient Name (Please Print)

______________________________ ______________________________
Patient Signature Date

OR

____
Signature of Personal Representative

Authority of Personal Representative to Sign for Patient (check one):

□ Parent □ Guardian □ Power of Attorney □ Other: ______________________________

Please Note: It is your right to refuse to sign this Acknowledgement.

Dental Office Use Only

I tried to obtain written Acknowledgement by the individual noted above of receipt of our **Notice of Privacy Practices**, but it could not be obtained because:

___ An emergency prevented us from obtaining acknowledgement.

___ A communication barrier prevented us from obtaining acknowledgement.

___ The individual was unwilling to sign.

___ Other: ______________________________

______________________________ ______________________________
Staff Member Signature Date

Financial Agreement

Prior to starting any dental treatment, we will review your expected total and your estimated portion. We collect your estimated portion at the time of treatment and offer financing options to help make dental care affordable.

As a courtesy, if you have dental insurance, our office will file your dental treatment claims. Any payments made from your insurance will be applied directly to your account. Please note that you remain financially responsible for your dental treatment, and you will be billed for any outstanding balance that remains after insurance payments. Please be aware that the amount paid from insurance can vary from the estimated coverage. If the amount paid by insurance is greater than estimated, you will have a credit on your account. If the amount paid by insurance is less than estimated, you will be responsible for the remaining balance.

If you are making extended payments, we will keep your credit card on file to charge monthly.

It is your responsibility to keep your credit card information up-to-date and accurate. In the event that your card is declined, you will be charged a $40 fee for each missed payment unless new credit card information is provided within three days of missed payment.

Balances that have not been paid on for over 30 days will incur an additional $40 fee.

Any balances that have not been paid within 45 days will be charged a 40% collection fee on the remaining balance and turned over to an outside collection agency.

I have read and understand this policy.

Date ______________________________

Name ______________________________

Signature ______________________________

(Separate sheet for credit card information)

Patient Appointment Agreement

When our office books your appointment, we are setting aside a dedicated chair and time slot just for you. We only ask that if you must reschedule your appointment, that you please provide us with at least ***24 business hours' notice***. This courtesy makes it possible to give your reserved time slot to another patient who would be more than happy to accept.

****Two cancellations (with less than 24 hours' notice) or missed appointments within a 12 month period will result in loss of future appointment privileges.***

Every patient in our practice receives this unique reservation. When your appointment is made, a time is reserved, your materials are ordered, and we make special arrangements to be ready for your visit. Except for emergency treatment for another patient, you can expect us to be prompt. We, of course, would appreciate the same courtesy from you.

Patient or Guardians Signature: ______________________________

Patient or Guardians Printed Name: ______________________________

Date: ____________________