Platinum Dental, Inc.

Patient Registration

Please complete the following confidential information.

Patient's Name: _____

Mr. ____ Mrs. ____ Ms. ____ Miss ____ Dr. ____ Other ____

Name you prefer to be address by: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Employer Name: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Length of Employment: ____Mos./Yrs. Occupation: _____

If patient is a child, Parent's Name: _____

School's Name: _____

Grade: _____ Full Time Student: Yes ____ No ____

Home Phone: ( )_____

Work Phone: ( )_____

Cell Phone: ( )_____

E-mail:_____

Social Security #: _____-_____-_____

Birth Date: ____/____/_____Male __ Female __

Married ___ Single ____ Divorced ____ Other _____

Person to contact in case of an emergency:

Name: _____ Relation: _____

Phone: ( )_____

Alternate Phone: ( )_____

Name of Person Responsible for this Account: _____

Please complete the following information in full if you would like us to assist you with your insurance claims.

Primary Dental Insurance Company: _____Phone ( )_____

Group/Policy #: _____ID #: _____Subscriber is: Self _____ Spouse _____

Secondary Dental Insurance Company: _____ Phone ( )_____

Group/Policy #: _____ID#: _____Subscriber is: Self _____ Spouse _____

Medical Insurance Company:_____ Phone ( )_____

Group/Policy #:_____ ID#: _____Subscriber is: Self _____ Spouse _____

If the insurance coverage is through your spouse, please provide us with Spouse's Name:_____

Spouse's Employer Name:_____Phone: ( ) _____ext.:_____

Spouse's Employer Address: _____

Spouse's Social Security Number: Spouse's Birth Date:

How did you hear about our office? *(Please circle):* Banner Flyer Internet Website Yellow Pages Patient Doctor Other

Whom may we thank for referring you to us? _____

I hereby authorize the release of any information required to complete my insurance claims and further authorize payment directly to Platinum Dental, Inc. for any benefits otherwise payable to me for their professional services. A copy of this authorization may be used in place of the original. To avoid misunderstanding regarding insurances, we wish our patients to know that all services rendered are charged directly to the patient and that the patient is **responsible for all fees not paid by the insurance company.**

Signature:_____ Date:_____

(Patient/Responsible party)

Platinum Dental, Inc.

Medical & Dental Health History

Do You have or have you had any of the following? Please check only if yes.

- ☐ Artificial heart valves
- ☐ Infective endocarditis
- ☐ Congenital heart disease/defect
- ☐ Prosthetic joints/hips/knees
- ☐ Pacemaker Date
- ☐ Heart attack Date
- ☐ Stroke Date
- ☐ Diabetes
- ☐ Blood pressure: high/low
- ☐ Bleeding/clotting disorder
- ☐ Hepatitis/Liver disease
- ☐ Blood disorder, anemia, leukemia
- ☐ Kidney disorder/failure
- ☐ Tired/aching jaw muscles
- ☐ Jaw/facial pain/soreness/tingling/numb
- ☐ Headaches
- ☐ Neck/back pain/stiffness/soreness
- ☐ Shoulder/arm pain/tingling/numb
- ☐ Tinnitus/ringing in ears
- ☐ Ear stuffiness/fullness
- ☐ Earaches/Itchy ears
- ☐ Dizziness/Loss of balance
- ☐ Crooked/missing teeth/change in bite
- ☐ Locked/stuck/difficulty opening/closing
- ☐ Clicking/popping jaw eating/talking
- ☐ Difficulty chewing/swallowing/choking
- ☐ Lung trouble (TB, COPD, asthma, emphysema)
- ☐ Shortness of breath or hyperventilation
- ☐ Arthritis, Rheumatoid, Degenerative Joint Disease
- ☐ Convulsions/seizures/epilepsy/fainting spells
- ☐ Anxiety/nervous/mood disorders/imbalance
- ☐ Indium, cobalt, lithium therapy
- ☐ Cancer/tumor/masses benign/malignant
- ☐ Radiation therapy/chemotherapy
- ☐ Gastrointestinal disorders
- ☐ HIV/AIDS/Auto-immune disorders
- ☐ Sexually transmitted diseases/venereal disease
- ☐ Surgeries:
- ☐ Other:

Are you now taking any medications? (check only those that apply)

- ☐ Pain
- ☐ Headaches
- ☐ Arthritis
- ☐ Allergy
- ☐ GERD
- ☐ Stomach
- ☐ Cholesterol
- ☐ Thyroid
- ☐ Blood pressure
- ☐ Blood thinners
- ☐ E.D.
- ☐ Weight loss
- ☐ Osteoporosis
- ☐ Sleeping
- ☐ Anxiety
- ☐ Birth Control
- ☐ Hormone
- ☐ Vitamins
- ☐ Herbal
- ☐ Other

List current medications below

Primary Care Doctor | Date of Last Medical Exam: | Phone:

(women only) Any possibility you are pregnant? ◯ Yes ◯ No

Are you allergic to, have gotten sick from or been told to avoid any of the following?

- ☐ Latex
- ☐ Antibiotics
- ☐ Aspirin/NSAID's
- ☐ Metals
- ☐ Narcotics
- ☐ Anesthetics

Please list what you are allergic to (meds/other)

Have you taken Oral Bisphosphonates like Fosomax (Alendronate)? ◯ Yes ◯ No

Have you taken diet drug Fen-Phen in the past? ◯ Yes ◯ No

Have you seen a dentist in the last 12 months?	◯ Yes	◯ No
Do you currently have dental or facial pain?	◯ Yes	◯ No
Do your gums bleed when you brush or floss?	◯ Yes	◯ No
Do you wake up with sore teeth or tired jaws?	◯ Yes	◯ No
Have you been told you snore loudly?	◯ Yes	◯ No
Do you have any teeth that hurt when you eat?	◯ Yes	◯ No
Do you have crooked or missing teeth?	◯ Yes	◯ No
Do you get anxious or nervous going to dentist?	◯ Yes	◯ No

What is your main reason for seeking dental care now?

- ☐ Check-up
- ☐ TMJ Pain
- ☐ Braces/Invisalign
- ☐ Implants
- ☐ Emergency
- ☐ Sedation dentistry
- ☐ Sleep apnea/Snoring
- ☐ Improve smile/appearance
- ☐ Full mouth reconstruction
- ☐ Whitening
- ☐ Other

I, the undersigned, have given the above information, have reviewed it an find it accurate. If there are any later changes, I will so inform the practice.

Patient signature:

Patient name: Date:

Submit by Email

Print Form

PLATINUM DENTAL, Inc.

555 S. Rancho Santa Fe Road, #100
San Marcos, CA 92078
Phone (760) 510-9009
Fax (760) 510-8008
www.platinumdental.com

Consent of Treatment

I hereby give consent to the doctors at Platinum Dental Inc. to take radiographs, study models, or any other diagnostic aids deemed appropriate by the doctors to make a thorough diagnosis of my dental needs. I also authorize and consent the doctors to perform and employ any and all forms of treatment, medication, and therapy, which may be indicated in connection with my dental needs. I understand the use of anesthetic agents embodies a certain risk. You may obtain a copy of the "*Dental Material Fact Sheet*".

_____ _____

Signature (Patient/Responsible Party) **Date**

HIPAA Consent of Disclosure

(For the Usage and /or Disclosure of Protected Health Information accordingly to the Health Insurance Portability and Accountability Act of 1966 (HIPAA))

I hereby give consent to Platinum Dental Inc. and all health care providers furnishing care with Platinum Dental Inc. to use and disclose my Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations.

Our posted Privacy Policy Notice (in reception room) provides more detailed information about the usage and disclosure of your Protected Health Information. You have the right to review our posted Privacy Policy Notice before you sign this consent.

You may cancel this consent at any time. Your cancellation must be in writing, signed by you or on your behalf and delivered to the address at the top of this form. This may be delivered in person or by mail, but it will be only be effective when we actually receive it. Your cancellation will not be effective to the extent that we or others have acted in reliance upon this consent.

You have the right to request restrictions on the usage and disclosure of your protected health information for the purposes of treatment, payment or health care operations. We are not required to grant your request, however, if we do, the restriction will be obligatory to us.

We reserve the right to amend the terms of our posted Privacy Policy Notice. You may obtain a copy of the current posted Privacy Policy Notice upon request.

I understand that this consent shall remain in force so long as I am a patient of this practice.

_____ _____

Signature (Patient/Responsible Party) **Date**

_____

Patient Name (Print)