Holton Dental

785-364-3038

Minor Patient Registration Form

Person Filling Out This Form:_____ Relationship to Patient:_____

Patient Information:

First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name (if different from name listed): _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____

Birth Date: _____ Social Security: _____

Email:_____

Preferred Dentist: ◯ No Preference ◯ Dr. Gilliland ◯ Dr. Rieschick

Responsible Party (Parent/Guardian Information):

First Name: _____ Last Name: _____ Middle Initial: ____

Preferred Name (if different from name listed): _____

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Work Phone: _____ Ext: _____ Home: _____

Birth Date: _____ Social Security: _____ Drivers License: _____

Email:_____

Dental Insurance Information:

Insurance Carrier:_____

Employer:_____

Policy Holder First Name: _____ Last Name: _____ Middle Initial: ____

Birth Date: _____ Social Security: _____ Drivers License: _____ Phone:_____

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Patient Registration Form (continued)

If you do not carry dental Insurance or are interested in replacing your current dental insurance plan, would you like more information about our *Holton Dental Membership Program* to help make your dental care more affordable? ◯ **YES** ◯ **NO**

Previous Dentist or Dental Office that may have your past dental records or x-rays:

_____

How did you hear about our office? _____

If someone referred you, whom may we thank for referring you to our office? _____

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Consent for Treatment and Agreement

Dr. Gilliland and Dr. Rieschick strive to provide excellent dental care at a reasonable cost to you and your family. Their schedule is very busy, but they will always spend as much time with you and your child as necessary so that the procedures are performed correctly, and so that you understand exactly what they are doing.

IF YOU HAVE ANY QUESTIONS ABOUT THE INFORMATION ON THIS PAPER, DO NOT SIGN IT UNTIL YOU HAVE SPOKEN TO DR. GILLILAND OR DR. RIESCHICK OR A STAFF MEMBER AND COMPLETELY UNDERSTAND ALL ITEMS.

By signing below, you agree:

1. That Dr. Gilliland and/or Dr. Rieschick may treat you or your child. You agree that Dr. Gilliland, Dr. Rieschick and/or the staff may perform an initial evaluation on you or your child, after which they will prepare a treatment plan and provide you a copy. You also agree that Dr. Gilliland and/or Dr. Rieschick may provide treatment to you or your child pursuant to that treatment plan, and that a subsequent consent need not be signed.
2. To keep your appointments and to show up at the scheduled time. If you are unable to keep your appointment, you agree to notify Dr. Gilliland and/or Dr. Rieschick at least 24 hours in advance. If you do not notify them in advance, or if you fail to keep your appointment, you agree that Dr. Gilliland and/or Dr. Rieschick may charge your account a cancellation fee of $30.
3. To pay your bill promptly. Dr. Gilliland and/or Dr. Rieschick are performing a valuable service at your request, and deserve to be paid in a timely manner. You agree, therefore, that you will pay your portion of the bill at the time of service, and any remaining balance after insurance has paid its portion of the bill, and you assign your right to insurance payments to Dr. Gilliland and/or Dr. Rieschick. You agree that even if you have insurance, you are responsible for seeing that the bill is paid. If your insurance has not paid for the charges within sixty (60) days of service, you agree to pay the balance on the charges. If you do not pay the bill, you agree that Dr. Gilliland and/or Dr. Rieschick may refer the matter to an attorney or collection agency for collections, and that in such event, you will pay a $50.00 collection cost, attorney fees, and court costs.
4. To inform us if you or your child's information changes. You agree that even if someone else brings you or your child to see Dr. Gilliland and/or Dr. Rieschick, you are still financially responsible for the bill. If you wish someone else to pay the bill, that person will have to sign this agreement. You also agree that unless you notify us in writing of a different address, the address you supply us with initially is the one we will send all statements to.
5. If you have dental insurance: Holton Dental is a contracting provider with Blue Cross Blue Shield of Kansas and Delta Dental. We will file these claims electronically for you. The difference of payment from your insurance company is due at time of service. If you have a different insurance company that we are not a contracting provider for we will submit your insurance at time of service and your balance is due at appointment.

ACKNOWLEDGEMENT OF NOTICE

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we receive your revocation, and that we may decline to treat you if you revoke this consent.

*I have had full opportunity to read and consider this Consent form. I understand that, by signing this Consent, I am giving my consent to your use and disclosure to my protected health information to carry out treatment, payment activities, and health care operations.

Signature of Person Responsible for Payment: _____ Date: _____

Social Security #- _____ Birth Date: _____

Patient Name: (if not self) _____ Relationship to Patient: _____

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Notice Of Privacy Practices-HIPPA

Patient Name: _____ Patient Birthday:_____

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. I authorize Holton Dental to release health information identifying me including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services. We may disclose your health information for different purposes, including treatment, payment and health care options. We will release this information to individuals involved in your care or law enforcement requiring patient information.

Please initial on lines below:

1. Detailed description of the information to be released:

   _____All Dental Records/Medical Information

2. To whom may the information be released:

   _____Medical Doctor

   _____Spouse _____

   _____Children

   _____Other

3. If someone inquires you are in our office today, are we able to release that information?

   _____ Yes _____No

I have read and understand this form. I authorize the disclosure of my health information as described in this form.

Date: _____ Patient Signature: _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient: _____ Print Name: _____

Signature of Authority: _____

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Authorization for Release of Communication

Patient Name: _____

Patient Birthday: _____

I authorize Holton Dental to release **health** and **account** information identifying me through electronic ways of communication, some of these methods, being unencrypted:

Please initial on lines below:

1. I release my information via:

    a. _____ E-mail E-mail address _____

    b. _____ Texting Cell Phone number _____

    c. _____ Voicemail

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written notice telling us that your authorization is revoked. Some information released from Holton Dental is in unencrypted form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect your confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes.

I have read and understand this form. I am signing it voluntarily. I authorize the disclosure of my health information as described in this form. Knowing my information will be sent in unencrypted methods.

Dated _____ Patient Signature _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to patient _____Print Name:_____

Signature of Authority_____

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Medical Health History

Patient Name: _____ Date:_____

Although we as dental professionals primarily treat your mouth, many health problems you have or medications you take can affect your dental care. Please answer the following to the best of your ability:

Are you under a physicians care now? ◯ Yes ◯ No
If yes, who and at what office?_____

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No
If yes, what/when?_____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No
If yes, what/when?_____

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No
If there are several, please feel free to list medications on the back of this form.
_____

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No
If yes, when?_____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing biphosphonates? ◯ Yes ◯ No
If yes, what/when?_____

Are you on a special diet? ◯ Yes ◯ No
If yes, please describe:_____

Do you use tobacco or E-Cigarettes? ◯ Yes ◯ No
If yes, indicate what type: _____
How long have you used this product?_____ How many packs/cans per day?_____

Do you use alcohol? ◯ Yes ◯ No
If yes, please clarify:
◯ Never ◯ Occasionally ◯ Monthly ◯ Weekly ◯ Daily ◯ 4+per Day

Do you use controlled substances? ◯ Yes ◯ No
If yes, please clarify:_____

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, Please List:_____

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Do you have, or have you had, any of the following?

AIDS/HIV Positive	◯ Yes	◯ No
Alzheimer's disease	◯ Yes	◯ No
Anaphylaxis	◯ Yes	◯ No
Anemia	◯ Yes	◯ No
Angina	◯ Yes	◯ No
Arthritis/Gout	◯ Yes	◯ No
Artificial Heart Valve	◯ Yes	◯ No
Artificial Joint	◯ Yes	◯ No
Asthma	◯ Yes	◯ No
Blood Disease	◯ Yes	◯ No
Blood Transfusion	◯ Yes	◯ No
Breathing Problems	◯ Yes	◯ No
Bruise Easily	◯ Yes	◯ No
Cancer	◯ Yes	◯ No
Chemotherapy	◯ Yes	◯ No
Chest pain	◯ Yes	◯ No
Cold Sores/Fever Blisters	◯ Yes	◯ No
Congenital Heart Disorder	◯ Yes	◯ No
Convulsions	◯ Yes	◯ No
Cortisone Medicine	◯ Yes	◯ No
Diabetes (last a1c:)	◯ Yes	◯ No
Drug Addiction	◯ Yes	◯ No
Easily Winded	◯ Yes	◯ No
Emphysema	◯ Yes	◯ No
Epilepsy or Seizures	◯ Yes	◯ No
Excess Bleeding	◯ Yes	◯ No
Excessive Thirst	◯ Yes	◯ No
Fainting/Dizziness	◯ Yes	◯ No
Frequent Cough	◯ Yes	◯ No
Frequent Diarrhea	◯ Yes	◯ No
Frequent Headaches	◯ Yes	◯ No
Genital Herpes	◯ Yes	◯ No
Glaucoma	◯ Yes	◯ No
Hay Fever	◯ Yes	◯ No
Heart Attack/Failure	◯ Yes	◯ No
Heart Murmur	◯ Yes	◯ No
Heart Pacemaker	◯ Yes	◯ No
Heart Trouble/Disease	◯ Yes	◯ No

Hemophilia	◯ Yes	◯ No
Hepatitis A	◯ Yes	◯ No
Hepatitis B or C	◯ Yes	◯ No
Herpes	◯ Yes	◯ No
High Blood Pressure	◯ Yes	◯ No
High Cholesterol	◯ Yes	◯ No
Hives or Rash	◯ Yes	◯ No
Hypoglycemia	◯ Yes	◯ No
Irregular Heartbeat	◯ Yes	◯ No
Kidney Problems	◯ Yes	◯ No
Leukemia	◯ Yes	◯ No
Liver Disease	◯ Yes	◯ No
Low Blood Pressure	◯ Yes	◯ No
Lung Disease	◯ Yes	◯ No
Mitral Valve Prolapse	◯ Yes	◯ No
Osteoporosis	◯ Yes	◯ No
Pain in Jaw Joints	◯ Yes	◯ No
Parathyroid Disease	◯ Yes	◯ No
Psychiatric Care	◯ Yes	◯ No
Radiation Treatment	◯ Yes	◯ No
Recent Weight Loss	◯ Yes	◯ No
Renal Dialysis	◯ Yes	◯ No
Rheumatic Fever	◯ Yes	◯ No
Rheumatism	◯ Yes	◯ No
Scarlet Fever	◯ Yes	◯ No
Shingles	◯ Yes	◯ No
Sickle Cell Disease	◯ Yes	◯ No
Sinus Trouble	◯ Yes	◯ No
Spina Bifida	◯ Yes	◯ No
Stomach/Intestinal Disease	◯Yes	◯ No
Stroke	◯ Yes	◯ No
Swelling of Limbs	◯ Yes	◯ No
Thyroid Disease	◯ Yes	◯ No
Tonsillitis	◯ Yes	◯ No
Tuberculosis	◯ Yes	◯ No
Tumors or Growths	◯ Yes	◯ No
Ulcers	◯ Yes	◯ No
Venereal Disease	◯ Yes	◯ No
Yellow Jaundice	◯ Yes	◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please clarify: _____

_____

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: