

REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____
SS/HIC/Patient ID # _____
Patient Name _____
Last Name _____
First Name _____ Middle Initial _____
Address _____
City _____
State _____ Zip _____
E-mail _____
Sex M F Age _____
Birthdate _____
 Married Widowed Single Minor
 Separated Divorced Partnered for _____ years
Occupation _____
Patient Employer/School _____
Employer/School Address _____
Employer/School Phone (_____) _____
Spouse's Name _____
Birthdate _____
SS# _____
Spouse's Employer _____
Whom may we thank for referring you? _____

2 DENTAL INSURANCE

Who is responsible for this account? _____
Relationship to Patient _____
Insurance Co. _____
Group # _____
Is patient covered by additional insurance? Yes No
Subscriber's Name _____
Birthdate _____ SS# _____
Relationship to Patient _____
Insurance Co. _____
Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to _____
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative _____

Please print name of Patient, Parent, Guardian or Personal Representative _____

Date _____

Relationship to Patient _____

3 PHONE NUMBERS

Home (_____) _____ Work (_____) _____ Ext _____ Cell Phone (_____) _____
Spouse's Work (_____) _____ Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____
Home Phone (_____) _____ Work Phone (_____) _____

4 DENTAL HISTORY

Reason for today's visit _____	Chew on one side of mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth breathing <input type="checkbox"/> Yes <input type="checkbox"/> No
Former Dentist _____	Cigarette, pipe, or cigar smoking <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth pain, brushing <input type="checkbox"/> Yes <input type="checkbox"/> No
City/State _____	Clicking or popping jaw <input type="checkbox"/> Yes <input type="checkbox"/> No	Orthodontic treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental visit _____	Dry mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Pain around ear <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental X-rays _____	Fingernail biting <input type="checkbox"/> Yes <input type="checkbox"/> No	Periodontal treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
Place a mark on "yes" or "no" to indicate if you have had any of the following:	Food collection between the teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to cold <input type="checkbox"/> Yes <input type="checkbox"/> No
Bad breath <input type="checkbox"/> Yes <input type="checkbox"/> No	Foreign objects <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to heat <input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding gums <input type="checkbox"/> Yes <input type="checkbox"/> No	Grinding teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to sweets <input type="checkbox"/> Yes <input type="checkbox"/> No
Blisters on lips or mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Gums swollen or tender <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity when biting <input type="checkbox"/> Yes <input type="checkbox"/> No
Burning sensation on tongue <input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw pain or tiredness <input type="checkbox"/> Yes <input type="checkbox"/> No	Sores or growths in your mouth <input type="checkbox"/> Yes <input type="checkbox"/> No
	Lip or cheek biting <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you floss? _____
	Loose teeth or broken fillings <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you brush? _____

5 HEALTH HISTORY

Physician's Name _____ Date of last visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). Yes No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

- | | | | | | |
|--|--|-----------------------|--|---------------------------------|--|
| AIDS/HIV | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Respiratory Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting or dizziness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis, Rheumatism | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valves | <input type="checkbox"/> Yes <input type="checkbox"/> No | Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shortness of Breath | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Joints | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Skin Rash | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Back Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis Type _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | Special Diet | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding abnormally, with extractions or surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Feet or Ankles | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaundice | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Neck Glands | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemical Dependency | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaw Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemotherapy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillitis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Circulatory Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congenital Heart Lesions | <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumor or growth on head or neck | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cortisone Treatments | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral Valve Prolapse | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcer | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cough, persistent or bloody | <input type="checkbox"/> Yes <input type="checkbox"/> No | Nervous Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No | Weight Loss, unexplained | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Emphysema | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | | Radiation Treatment | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

Do you wear contact lenses? Yes No

Women:

Are you pregnant? Yes No Due date _____ Are you nursing? Yes No
 Taking birth control pills? Yes No

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

Pharmacy Name _____

Phone (_____) _____

ALLERGIES

- | | |
|--|---|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Local Anesthetic |
| <input type="checkbox"/> Barbiturates (Sleeping pills) | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Iodine | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Latex | _____ |

0 UPDATES (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? Yes No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Has there been any change in your health since your last dental appointment? Yes No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____



STATEMENT OF PRIVACY PRACTICES

We are dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principle concept of our practice. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect your rights.

Protecting Your Personal Healthcare

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act. This includes issues relating to your treatment, payment, and our dental care operations. You may give written authorization for us to disclose your information to anyone you choose, for any purpose but it will never otherwise be given to anyone - even family members - without your written consent.

Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality of your records is always protected. Our privacy and practices apply to all current and former patients, so you can be confident that your protected health information will never be improperly disclosed or released.

Collecting Protected Health Information

We will only request personal information needed to provide our standard of quality dental care, implement payment activities, conduct normal dental practice operations and comply with the law. This may include your name, address, telephone number(s), Social Security number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, the information will always be protected to the full extent of the law.

Disclosure of your Protected Health Information

As stated above, we may disclose information as required by law. This includes issues in which we reasonably believe you may be a victim of abuse, neglect, domestic violence or other crimes. We are also obligated to provide information to law enforcement officials under certain circumstances. We will not use your information for marketing purposes without your written consent.

We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines, and postcards.

Patient Rights

You have a right to get copies of your healthcare information; to obtain copies in a variety of formats; and to a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can, also, notify the U.S. Department of Human Services.

We thank you for being a patient at our practice. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.

Michael N. Morgan DDS and Sterling L. Rogers DDS

3208 N. Academy Blvd., Suite 110 • Colorado Springs, CO 80917 • Phone: (719) 597-3700 • Fax: (719) 597-7507



**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**
****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's
Notice of Privacy Practices.

(Signature)

(Date)

Please check appropriate boxes to indicate where we may leave messages if we do not talk to you personally.

Work:

- Co-Worker
- Recorder

Home:

- Other family members
- Recorder
- Cell phone

For Office Use Only: We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other

Photographs:

- Self
- Family



Failed or broken appointments cause a waste of valuable professional time and deprive others of treatment. If due to unforeseen circumstances, you must cancel your dental appointment, at least forty-eight hours notification should be given to enable us to fill your appointment period. With proper notification, another appointment may be given over the phone.

It is considered a failed appointment if the following occurs:

1. You do not appear at your appointment time.
2. You do not give sufficient prior notice of cancellation (48 hours).
3. You arrive at the dental office over 10 minutes late.

If during the course of treatment you fail an appointment without a valid reason, you will be charged \$30.00 per hour. Another appointment will not be made until the fee is paid.

If during the course of treatment you fail a second appointment without a valid reason, a consultation with Dr. Morgan or Dr. Rogers will be scheduled to discuss further treatment in this dental office.

This policy is not designed to create hardship, but to eliminate wasted professional time so you may receive the more efficient dental care!

I HAVE READ AND UNDERSTAND THE ABOVE POLICY.

Patient's (or guardian's) signature

Date

Michael N. Morgan DDS and Sterling L. Rogers DDS

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