Divine DENTAL CENTER

REGISTRATION FORM

(Please Print)

PATIENT INFORMATION

Patient's last name: First: Middle initial:			❑ Mr. ❑ Mrs. ❑ Dr.	❑Miss. ❑Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Preferred Name :					
Home phone no.: ( )	Work phone no.: ( )	Cellular phone no.: ( )	Birth date: / /		Sex: ❑ M ❑ F
Street address:	Social Security no. or Member ID:		E mail: @		
P. O. box or Apt #	City:	State:	Zip code:		
How did you hear about our office? :		May we contact this person? ❑ Yes ❑ No ❑ N/A			

RESPONSIBLE PARTY INFORMATION

Last name: First: Middle:			❑ Mr. ❑ Mrs. ❑ Dr.	❑Miss. ❑Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Home phone no.: ( )	Work phone no.: ( )	Cellular phone no.: ( )	Birth date: / /		Sex: ❑ M ❑ F
Street address:	Social Security no. or Subscriber ID:		E mail: @		
P. O. box or Apt #	City:	State:	Zip code:		

POLICY HOLDER'S INFORMATION

Last name: First: Middle: Employer: Insurance Company:			❑ Mr. ❑ Mrs. ❑ Dr.	❑Miss. ❑Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Home phone no.: ( )	Work phone no.: ( )	Cellular phone no.: ( )	Birth date: / /		Sex: ❑ M ❑ F
Street address:	Social Security no. or Subscriber ID:		E mail: @		
P. O. box or Apt #	City:	State:	Zip code:		

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Cell Phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Divine Dental Center. I understand that I am financially responsible for any balance. I also authorize Divine Dental Center or insurance company to release any information required to process my claims.

Patient/Guardian signature

Date

Time 12:16 PM | Divine Dental Center | Date 11/28/2014

Eaglesoft Medical History

Patient Name: | Birth Date: | Date Created:

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
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes
Are you taking any medications, pills, or drugs?	○ Yes ○ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Are you on a special diet?	○ Yes ○ No	
Do you use tobacco?	○ Yes ○ No	

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	
Do you use controlled substances?	○ Yes ○ No	If yes	

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

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 Problems	○ 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	○ Yes ○ No	If yes	

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:

X Date:_____

Divine Dental Center
3295 Franklin Road
Murfreesboro, TN 37128
www.divinedentalcenter.com
615.896.7274

PATIENT NAME: _____ **DATE:** _____

Medication Information

In an effort to make a more accurate diagnosis, we ask that you please disclose any medications that you are taking on a daily basis whether they are prescribed or over-the-counter. Please feel free to ask our staff for additional sheets if necessary.

For Example:
Name: Lotensin_____
Dosage: 20 mg_____
Frequency/Time of Day: 1 a day; A.M._____
Condition: High Blood Pressure_____

Name:_____
Dosage:_____
Frequency/Time of Day:_____
Condition:_____

Name:_____
Dosage:_____
Frequency/Time of Day:_____
Condition:_____

Name:_____
Dosage:_____
Frequency/Time of Day:_____
Condition:_____

Name:_____
Dosage:_____
Frequency/Time of Day:_____
Condition:_____

Patient Signature: _____ Date: _____

Divine Dental Center

Dental Health Form

Patient's Name: _____

Previous Dentist: _____ How long were you a patient? __Months/Years

Reason for leaving: _____

Date of most recent dental exam _/_____/_____ Date of most recent x-rays _____/_____/_____

Date of most recent treatment (other than a cleaning) /_____/_____Type of treatment: _____

1. Are you having any discomfort at this time? Explain: _____
2. Have you ever had any serious complications associated with previous dental procedures? Explain: _____
3. Does dental treatment make you nervous? No _ Slightly ____ Moderately _____Extremely _____
4. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? _____
   If so, when: _____
5. How often do you brush? _____Toothbrush is: soft _____ Medium ____Hard__
6. How often do you floss your teeth? _____
7. Do you have, or have you ever had any of the following? Please check those that apply:

MOUTH	TEETH
□Bleeding, sore gums	□ Loose teeth
□ Unpleasant taste/bad breathe	□ Sensitivity to heat
□ Burning tongue/lips	□ Sensitivity to cold
□ Frequent blisters, lips or mouth	□ Sensitivity to sweets
□ Swelling/lumps in mouth	□ Sensitivity to biting
□ Braces	□ Food impaction
□ Biting of cheeks/lips	□ Clenching/grinding
□ Clicking/popping jaw	If so, when? _____
□ Difficulty opening or closing jaw	□ Shifting in bite
	□ Change in bite

8. Are you happy with your smile and the appearance of your teeth in general (Color, Shape, Spaces)? Yes or No
   If no, why not? _____
9. How would you rate the condition of your mouth? □ Excellent □ Good □ Fair □ Poor

Patient/Responsible party's Signature: _____ Date_____

Divine DENTAL CENTER

FINANCIAL POLICY

- I understand that I am responsible for all fees related to my dental care and treatment.
- I understand that full payment for all dental treatment is to be paid at the time of service. For your convenience we accept Cash, CareCredit, Citi Healthcare Card, Discover, MasterCard and Visa.
- **I understand that a deposit maybe required for scheduling subsequent appointments after the initial exam.**
- I understand that any and all account balances over 30 days old may incur a monthly interest charge at the maximum rate.
- I understand that if any electronic authorization or debit sent or provided to Divine Dental Center for payment is not honored upon first presentation, regardless of the reason, even if the electronic authorization was later honored. I may be charged a service fee.
- I understand that if my account is not paid on time, my account may be turned over to collection agency. In addition to paying my balance, I agree to pay all Attorneys' fees, collection and/or other court costs.

BROKEN AND/OR MISSED APPOINTMENTS

- Divine Dental Center requires a **forty eight (48) hours notice** for any appointment changes.
- Divine Dental Center reserves the right to charge a **$50 fee** for any appointment not kept by the patient. After one (1) broken or missed appointment, the dentist retains the right to provide only emergency care, discontinue elective treatment or dismiss the patient from the practice.
- Divine Dental Center reserves the right to only schedule one (1) or (2) patients per family after one (1) no show/missed/or cancelled appointment for a family of two (2) or more patients.
- **Divine Dental Center reserves the right to notify insurance companies that provide state aid, if a patient fail's to show for more than one (1) appointment. This could affect your benefits.**

PATIENTS WITH DENTAL INSURANCES

- I **understand that my insurance policy is a contract between My Insurance Company and Myself**. Divine Dental Center and its employees are not parties to my contract with my insurance company.
- **I understand that I am ultimately responsible for any and all balances, even if my insurance company agrees to pay a balance and later does not pay.**
- I understand that I may be given the option of only paying my **estimated** portion (that portion not covered by insurance) at the time of services. **As a courtesy, the office will send my claim to my insurance company. If my insurance fails to pay their estimated portion after 45 days, the balance is my responsibility and payment is due in full.**
- I understand that if my first visit is an emergency visit, I will be responsible for payment of services in full at the time of the visit. As a courtesy, Divine Dental Center may provide to me the necessary documents to file to my insurance company for reimbursement.

I have read, understand and agree to the above Divine Dental Center Office Financial Policy.

_____ _____

Signature of Patient/Responsible Party Date

Divine
DENTAL CENTER

Osayomore Eguakun, DDS
3295 Franklin Road, Murfreesboro,TN 37128
615-896-7274; 615-896-7299 (fax)
info@divinedentalcenter.com

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient name_____ Date: _____

I authorize the professional office of my dentist named above 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] under the terms and conditions outlined in the Notice of Privacy Practices.

1. My information may also be released to my family member(s) or friend(s) listed below:

- To whom may the information be released [name(s) or class(es) of recipients]: _____
- Recipients relationship to patient: _____

2. When and for what purpose should your information be released to the above named individual(s)

- _____

3. State if any, expiration date to which your information may be released to your named individual(s)_____

4. Please circle all your preferred methods of communication and voicemail: E-Mail, Home Phone, Cell Phone, Text Message, Work Phone.

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 or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

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

[For marketing authorizations, include, as applicable: We will receive direct or indirect remuneration from a third party for disclosing your identifiable health information in accordance with this authorization.]

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 AND NOTICE OF PRIVACY PRACTICES.

Patient signature_____ Date_____

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_____

Source of Authority_____

For Practice 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 (Please Specify): _____