PATIENT REGISTRATION

First Name: _____ Last Name: _____ Birthdate: _____

Patient Information

First Name: _____Last Name: _____Middle Init: _____

Address: _____ City, State, Zip: _____

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

Sex: Male Female Marital Status: Married Single Divorced Separated Widowed

Birthdate: _____ SS#/SIN: _____Email: _____

Emergency Contact: _____ Emergency Contact #:_____ Relationship: _____

How did you hear about us? _____

Employment Status: Fulltime Part Time Retired N/A Employer Name_____

Student Status: Full Time Part Time School Name: _____

Previous Dentist: _____Date of Last Exam: _____

Responsible Party (If someone other than the patient is being seen today**)**

First Name: _____Last Name: _____Middle Init: _____

Address: _____City, State, Zip: _____

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

Birthdate: _____ Soc. Sec: _____Email: _____

Primary Insurance Information

Subscriber: _____ Relationship to Subscriber: Self Spouse Child Other

SS #/SIN: _____Insured Birthdate: _____Employer: _____

Insurance Company: _____Insurance active Date_____

Insurance Co. Address: _____ City, State, Zip: _____

Group#/ Employer _____ Member ID: _____

Secondary Insurance

Subscriber: _____ Relationship to Subscriber: Self Spouse Child Other

SS #/SIN: _____Insured Birthdate: _____Employer: _____

Insurance Company: _____Insurance active Date_____

Insurance Co. Address: _____ City, State, Zip: _____

Group#/ Employer _____ Member ID: _____

Late Charges/Cancellation Policy

Your appointment was scheduled to allow for enough time to provide the best service for you. If you find that you must change your appointment, we require a minimum of 48 business hours notice so that we may make every effort to accommodate other patients. If proper notice is not received, a $100 fee may be charged for every appointment cancelled or missed.

Patient Signature_____Date_____

HEALTH HISTORY

Patient Name: _____ Date of Birth: _____

DENTAL HEALTH HISTORY:

		YES	NO
1.	Reason for visit: _____		
2.	When was your last dental visit? _____		
3.	Do your gums bleed when you brush or floss?	☐	☐
4.	Do you feel any pain when brushing or flossing?	☐	☐
5.	Do you experience any teeth sensitivity when eating/drinking?	☐	☐
6.	Do you have any sores or lumps in or near your mouth?	☐	☐
7.	Do you clench or grind your teeth while awake or asleep?	☐	☐
8.	Do you bite your lips or cheek frequently?	☐	☐
9.	Are you satisfied with the appearance of your teeth?	☐	☐
10.	Have you ever had an upsetting experience in the dental office?	☐	☐
11.	Have you had any braces in the past?	☐	☐
12.	Have you ever had Oral surgery or gum treatment in the past?	☐	☐
13.	Have you ever worn a bite plate or other appliance?	☐	☐
14.	Does food tend to be caught between your teeth?	☐	☐

MEDICAL HISTORY:

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems 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.

		YES	NO
1.	Are you in good health?	☐	☐
2.	Have there been any changes in your general health within the last year?	☐	☐
3.	Are you currently under the care of a physician?	☐	☐
4.	Date of last physical exam: _____ Physician: _____ Physician's Phone No.: _____		
5.	Have you ever been hospitalized or had a major operation? Please explain (use back if needed): _____ _____ _____	☐	☐
6.	Do you **PRE-MEDICATE** for dental procedures due to joint replacements or heart related issues?	☐	☐
7.	Have you ever had a serious head, neck, or jaw injury?	☐	☐
8.	Are you taking any medicine(s) including non-prescription medicine and/or blood thinners? If yes, what? (use back if needed) _____ _____	☐	☐

		YES	NO
9.	Are you allergic to or have you had reactions to:		
	Local anesthetics like Novocain?	☐	☐
	Penicillin or other antibiotics?	☐	☐
	Sulfa Drugs?	☐	☐
	Barbiturates, sedatives or sleeping pills?	☐	☐
	Aspirin?	☐	☐
	Iodine?	☐	☐
	Latex?	☐	☐
	Other?	☐	☐
10.	Do you have a history of smoking and/or vaping?	☐	☐
11.	Do you have a history of cocaine, or another drug use?	☐	☐
12.	Do you use alcohol?	☐	☐
13.	Do you or a loved one experience snoring that keeps you up at night?	☐	☐
14.	Have you ever been diagnosed with Sleep Apnea?	☐	☐
15.	Have you ever taken Fosamax, Boniv, Actonel or any other medications containing bisphosphonates?	☐	☐

WOMEN ONLY: Are you:
- Pregnant/Trying to get pregnant?
- Taking Oral Contraceptives?
- Nursing?

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

☐AIDS/HIV Positive	☐Chest Pains	☐Genital Herpes	☐Kidney Problems	☐Renal Dialysis
☐Alzheimer's disease	☐Cold Sores/Fever Blisters	☐GERD	☐Leukemia	☐Rheumatic Fever
☐Anaphylaxis	☐Congenital Heart Disorder	☐Glaucoma	☐Liver Disease/Jaundice	☐Scarlet Fever
☐Anemia	☐Cortisone Medicine	☐Heart Attack/Failure	☐Low Blood Pressure	☐Seasonal Allergies
☐Angina	☐Diabetes	☐Heart Murmur	☐Lung Disease	☐Shingles
☐Arthritis/Gout	☐Drug Addiction	☐Heart Pacemaker	☐Lupus	☐Sickle Cell Disease
☐Artificial Heart Valve	☐Easily Winded	☐Heart Surgery/Disease	☐Mental Health Disorders	☐Sinus Trouble
☐Artificial Joint/Implant	☐Emphysema	☐Hemophilia	☐Mitral Valve Prolapse	☐Stomach/Intestinal Disease
☐Asthma	☐Epilepsy or Seizures	☐Hepatitis A, B or C	☐Oral Herpes	☐Stroke
☐Blood Disease	☐Excessive Bleeding	☐High Blood Pressure	☐Osteoporosis	☐Swelling of Limbs
☐Blood Transfusion	☐Excessive Thirst	☐High Cholesterol	☐Pain in Jaw Joints (TMJ)	☐Thyroid Disease
☐Breathing Problem	☐Fainting Spells/Dizziness	☐Hives or Rash	☐Parathyroid Disease	☐Tonsillitis
☐Bruise Easily	☐Frequent Cough	☐Hypoglycemia	☐Psychiatric Care	☐Tuberculosis
☐Cancer	☐Frequent Diarrhea	☐Infective Endocarditis	☐Radiation Treatments	☐Tumors or Growths
☐Chemotherapy	☐Frequent Headaches	☐Irregular Heartbeat	☐Recent Weight Loss	☐Ulcers

Have you had any serious illness or major surgeries not listed above? Yes No If yes, please explain: _____

_____

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_____

(flip over for additional space for notes)

Additional space for notes if needed:

Buffalo Dental Group, LLP

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgment

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

_____
Signature of Patient/Parent/Legal Guardian

_____
Date

Individuals authorized to receive my healthcare information:

_____
Please print name

_____
Please print name

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our HIPAA Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ❑ Individual refused to sign
- ❑ Communications barriers prohibited obtaining the acknowledgment
- ❑ An emergency situation prohibited us from obtaining acknowledgment
- ❑ Other (Please Specify)

_____
_____
_____

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect **April 14, 2003**, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such applicable law permits the changes. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We may use and disclose your health information for different purposes, including treatment, payment and healthcare operations. For example:

Treatment: We may use and disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved in your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations: We may use and disclose your health information in connection to our healthcare operations. This includes, quality assessment activities, employee review activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. We may also call you by name in our waiting room when your dentist or hygienist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To You and Your Family: We may disclose your health information to a family member who is responsible to the extent necessary to help with your healthcare or with payment of your healthcare. Before we disclose your health information to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event of your incapacity, or an emergency, we will disclose your dental information based on our professional judgement or whether the disclosure would be in your best interest.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonable believe that you are a possible victim of abuse, neglect, or domestic violence

Revoke This Authorization: At any time, in writing, you may revoke this authorization, except to the extent that your dentist or dental practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

You have the right to Inspect and copy your protected health Information with limited exceptions. You must make the request in writing. If you request information that we maintain on paper, we may provide photocopies. If you request information we maintain electronically, you have the right to an electronic copy.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

You have the right to request a restriction: This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends whom may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your dentist is not required to agree to a restriction that you may request. If the dentist believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

If you have any questions or concerns, please contact us.