DENTAL REGISTRATION AND HISTORY

(PLEASE PRINT)

The Burlin Dental Group
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Date ______ Home Phone (____) ______ Cell Phone (____) ______

PATIENT INFORMATION

Name ______ SS/HIC/Patient ID # ______
Last Name First Name Middle Initial

Address ______ E-mail ______

City ______ State ______ Zip ______

Sex ☐ M ☐ F Age ______ Birthdate ______ ☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Separated ☐ Divorced ☐ Partnered for ______ years

Patient Employer/School ______ Occupation ______

Employer/School Address ______ Employer/School Phone (____) ______

Whom may we thank for referring you? ______

In case of emergency who should be notified? ______ Phone (____) ______

PRIMARY INSURANCE

Person Responsible for Account ______
Last Name First Name Middle Initial

Relation to Patient ______ Birthdate ______ Soc. Sec. # ______

Address (If different from patient's) ______ Phone (____) ______

City ______ State ______ Zip ______

Person Responsible Employed by ______ Occupation ______

Business Address ______ Business Phone (____) ______

Insurance Company ______

Contract # ______ Group # ______ Subscriber # ______

Names of other dependents covered under this plan ______

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name ______ Birthdate ______ Relation to Patient ______

Address (If different from patient's) ______ Phone (____) ______

City ______ State ______ Zip ______

Subscriber Employed by ______ Business Phone (____) ______

Insurance Company ______ Soc. Sec. # ______

Contract # ______ Group # ______ Subscriber # ______

Names of other dependents covered under this plan ______

ASSIGNMENT AND RELEASE

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

______ Please print name of Patient, Parent, Guardian or Personal Representative ______ Relationship to Patient

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DENTAL HEALTH HISTORY
(Confidential)

DENTAL HISTORY

Reason for Today's Visit ______________________ Date of last dental care ______________________

Former Dentist ______________________ Date of last dental X-rays ______________________

Address ____

Check (✓) if you have had problems with any of the following

- ☐ Bad breath
- ☐ Grinding teeth
- ☐ Sensitivity to hot
- ☐ Bleeding gums
- ☐ Loose teeth or broken fillings
- ☐ Sensitivity to sweets
- ☐ Clicking or popping jaw
- ☐ Periodontal treatment
- ☐ Sensitivity when biting
- ☐ Food collection between teeth
- ☐ Sensitivity to cold
- ☐ Sores or growths in your mouth

How often do you floss? ______________________ How often do you brush? ______________________

MEDICAL 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

Have you had any serious illnesses or operations? ______________________ If yes, describe ______________________

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate date(s) ______________________

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (✓) if you have or have had any of the following:

- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

MEDICATIONS

List medications you are currently taking:

____

____

Pharmacy Name ______________________

Phone (____) ______________________

ALLERGIES

- ☐ Aspirin
- ☐ Barbiturates (Sleeping pills)
- ☐ Codeine
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Latex ______________
- ☐ Other ______________

____

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date ______________________ Signature ______________________

THE BURLIN DENTAL GROUP, LLC.

creating your smile while you relax

HIPAA Privacy Rule Receipt of Notice of Privacy Practices Written Acknowledgement Form

I ,______________________________, (patient's name) understand that as part of my oral healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment.

I acknowledge that I have been provided with and understand that this facility's **Notice of Privacy Practices** provides a complete description *of* the uses and disclosures of my health information. I understand that:

- ☐ I have the right to review this facility's **Notice of Privacy Practices** prior to signing this acknowledgement;
- ☐ This facility reserves the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy of any revised notice to the address I've provided if requested.

If you have any questions about your rights or our privacy practices, please send an electronic message (e-mail) to frontdesk@burlindentalgroup.com or a letter to:

The Burlin Dental Group, LLC
4687 Rockbridge Road. Ste # 7
Stone Mountain, GA 30083

By signing this form, you are only acknowledging that you have been provided our Notice.

Print Name of Patient______________________________

Print Name of Authorized Representative______________________________

Signature of Patient or Authorized Representative______________________________

Today's Date:____________________

FOR OFFICE USE ONLY

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

- ☐ Individual refused to sign
- ☐ Communication barrier prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Others (please specify) ______________________________