

**PATIENT REGISTRATION**

ID: \_\_\_\_\_ Chart ID: \_\_\_\_\_  
 First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_  
 Patient Is:  Policy Holder  Responsible Party Preferred Name: \_\_\_\_\_

Responsible Party ( if someone other than the patient )

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_  
 Address: \_\_\_\_\_ Address 2: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_ Pager: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Cellular: \_\_\_\_\_  
 Birth Date: \_\_\_\_\_ Soc Sec: \_\_\_\_\_ Drivers Lic: \_\_\_\_\_  
 Responsible Party is also a Policy Holder for Patient  Primary Insurance Policy Holder  Secondary Insurance Policy Holder

Patient Information

Address: \_\_\_\_\_ Address 2: \_\_\_\_\_  
 City: \_\_\_\_\_ State / Zip: \_\_\_\_\_ Pager: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Cellular: \_\_\_\_\_  
 Sex:  Male  Female Marital Status:  Married  Single  Divorced  Separated  Widowed  
 Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Soc Sec: \_\_\_\_\_ Drivers Lic: \_\_\_\_\_  
 E-mail: \_\_\_\_\_  I would like to receive correspondences via e-mail.

Section 2

Section 3

Employment Status:  Full Time  Part Time  Retired  
 Student Status:  Full Time  Part Time  
 Medicaid ID: \_\_\_\_\_ Pref. Dentist: \_\_\_\_\_  
 Employer ID: \_\_\_\_\_ Pref. Pharmacy: \_\_\_\_\_  
 Carrier ID: \_\_\_\_\_ Pref. Hyg: \_\_\_\_\_

Referred By \_\_\_\_\_  
 Previous Dentist \_\_\_\_\_  
 Emergency Contact \_\_\_\_\_  
 Emergency Contact # \_\_\_\_\_

Primary Insurance Information

Name of Insured: \_\_\_\_\_ Relationship to Insured:  Self  Spouse  Child  Other  
 Insured Soc. Sec: \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Ins. Company: \_\_\_\_\_  
 Address: \_\_\_\_\_ Address: \_\_\_\_\_  
 Address 2: \_\_\_\_\_ Address 2: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_  
 Rem. Benefits: \_\_\_\_\_ Rem. Deduct: \_\_\_\_\_

Secondary Insurance Information

Name of Insured: \_\_\_\_\_ Relationship to Insured:  Self  Spouse  Child  Other  
 Insured Soc. Sec: \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Ins. Company: \_\_\_\_\_  
 Address: \_\_\_\_\_ Address: \_\_\_\_\_  
 Address 2: \_\_\_\_\_ Address 2: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_  
 Rem. Benefits: \_\_\_\_\_ Rem. Deduct: \_\_\_\_\_

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
 Latex  Sulfa Drugs

Do you use controlled substances?  Yes  No If yes [ ]
Other?  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 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 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 Blood Transfusion  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 Low Blood Pressure  Yes  No Swelling of Limbs  Yes  No Cancer  Yes  No
Lung Disease  Yes  No Thyroid Disease  Yes  No Chemotherapy  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 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

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: \_\_\_\_\_

# ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

**Giesler Dental  
671 3rd Avenue  
Jasper, IN 47546**

**Acknowledgement**

I, \_\_\_\_\_, hereby acknowledge that I have received and reviewed a copy of Giesler Dental's *HIPAA Notice of Privacy Practices*.

I understand that Giesler Dental's *HIPAA Notice of Privacy Practices* may change periodically and that I am entitled to receive a copy of Giesler Dental's revised *HIPAA Notice of Privacy Practices* upon request.

I understand that, if I have questions about Giesler Dental's *HIPAA Notice of Privacy Practices*, I may contact Dr. Nicholas Giesler at 812-634-6425.

I understand that it is my right to refuse to sign this Acknowledgement should I so choose, and that Giesler Dental will not refuse treatment to me if I refuse to sign this Acknowledgement.

I further understand that I may contact the Secretary of the U.S. Department of Health and Human Services should I have concerns regarding Giesler Dental's privacy policies and procedures. For information on how to contact the U.S. Department of Health and Human Services, please ask Dr. Nicholas Giesler noted above, for assistance.

Patient Signature	Date
Signature of Personal Representative	Print Name of Personal Representative
	Relationship of Personal Representative to Patient

**FOR OFFICE USE ONLY**

Giesler Dental made a good-faith effort to obtain Acknowledgement, from the patient noted above, of receipt of its *HIPAA Notice of Privacy Practices*. In spite of these efforts, Giesler Dental was unable to obtain a signed Acknowledgement for the following reason(s):

- Refusal to sign Acknowledgement on \_\_\_\_\_, 20\_\_\_\_\_.
- Communications barriers prohibited us from obtaining a signed Acknowledgement.
- An emergency situation prohibited us from obtaining a signed Acknowledgement.
- Other (Describe): \_\_\_\_\_

Date Received	By	Patient ID

## GIESLER DENTAL TREATMENT CONSENT

I, \_\_\_\_\_, consent to be a patient at the above named office and agree to a radiographic and clinical examination. I **also understand and consent to the following:**

1. During the course of treatment, I may undergo procedures in all phases of dentistry including periodontics (gum treatment and surgery), oral surgery, endodontics (root canals), fixed and removable prosthodontics (crowns, bridges, and dentures), implant dentistry, restorative dentistry, temporomandibular disorder treatment, sleep apnea treatment, oral pathology, pediatric dentistry, and radiography.

2. I will provide a thorough and complete medical history, supply a full list of my medications with dosages, and consent to my dentist communicating with my other medical practitioners to inquire about any aspect of my health history.

3. I will pay in full any cost of treatment or insurance copayments according to the office's financial policy. I understand that even if an insurance preestimate is given or a procedure has been preapproved, I am responsible for *any* costs that my insurance does not cover.

4. My treatment plan may change at any time and I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist, and dental office staff.

5. I am welcome to ask questions about any aspects of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of treatment that I am unsure about.

6. I acknowledge that no guarantee or assurance has been made to me as to the results that maybe obtained or the life expectancy of the treatment.

\_\_\_\_\_  
Patient or Guardian Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date