DENTAL REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____

SS# _____

Patient Name _____

Address _____

City _____

State _____ Zip _____

Home Phone (___)_____ Work Phone (___)_____

Cell Phone (___)_____ E-Mail _____

Sex ❑ Male ❑ Female Age _____

Birth Date _____

❑ Married ❑ Widowed ❑ Single ❑ Minor

❑ Separated ❑ Divorced ❑ Partnered for ____years

Patient Employer/School _____

Whom may we thank for referring you? _____

2 GUARDIAN/SPOUSE CONTACT INFORMATION

Spouse's Name _____

SS# _____

Address (if different) _____

City _____

State _____ Zip _____

Home Phone (___)_____ Cell Phone (___)_____

Spouse's Employer _____

Work Phone (___)_____

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

Name _____

Relationship _____

Home Phone (___)_____

Work Phone (___)_____

3 DENTAL INSURANCE

Insurors/ed Name _____ Relationship to Patient _____

Birth Date & SS# _____

Insurance Co. _____ Group # _____

Insurance Co. Phone (___)_____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____
Name of Insurance Co.

And assign directly to Dr. Cauwels. 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.

_____
Sign and Date

4 DENTAL HISTORY

Reason for today's visit _____

Former Dentist _____ City/State _____

Date of last dental visit _____ Date of last dental x-rays _____

How often do you floss? _____ How often do you brush? _____

Please circle "yes" or "no" to indicate if you have any of the following:

yes	no	Bad breath	yes	no	Jaw pain or tiredness	yes	no	Are you happy with the color & shape of your teeth?
yes	no	Bleeding gums	yes	no	Loose teeth or broken filling			
yes	no	Blisters on lips or mouth	yes	no	Mouth breathing day or night	yes	no	Have you had a bad dental experience?
yes	no	Burning sensation on tongue	yes	no	Orthodontic treatment			
yes	no	Clicking or popping jaw	yes	no	Pain around ear			
yes	no	Dry mouth	yes	no	Periodontal treatment			
yes	no	Fingernail, lip or cheek biting	yes	no	Sensitivity to cold			
yes	no	Food collected between teeth	yes	no	Sensitivity to hot			
yes	no	Grinding teeth	yes	no	Sensitivity to sweet			
yes	no	Gums swollen or tender	yes	no	Sensitivity to biting			

Designer Dentistry & Smiles

5 HEALTH HISTORY

Physician's Name _____ Date of Last Visit _____

Have you ever taken any of the group of drugs collectively referred to as Bisphosphonates for the treatment of ostioporosis? These include combinations of Fosamax, Alendronate taken orally or an IV, Bisphosphonates. ❑ Yes ❑ No

Please "yes" or "no" to indicate if you have any of the following:

yes	no	Anemia or Bleeding Disorder	yes	no	HIV + AIDS	yes	no	Tuberculosis
yes	no	Arthritis	yes	no	Heart Disease/Problem	yes	no	Ulcer
yes	no	Artificial Heart Valve	yes	no	Hepatitis Type	yes	no	Venereal Disease
yes	no	Artificial Joints	yes	no	High Blood Pressure	yes	no	Eating Disorder
yes	no	Asthma	yes	no	Low Blood Pressure	yes	no	Circulatory Problems
yes	no	Attention Deficit Disorder	yes	no	Kidney Problems	yes	no	Tonsillitis
yes	no	Blood Transfusion	yes	no	Liver Disease	yes	no	Taken Phen Fen
yes	no	Cancer Chemotherapy	yes	no	Mitral Valve Prolapse	yes	no	Snore
yes	no	Bowel Disorder	yes	no	Pacemaker	yes	no	Sleep Apnea
yes	no	Congenital Heart Defect	yes	no	Lung Disease			(If yes, what treatment)
yes	no	Diabetes	yes	no	Anxiety or Depression			_____
yes	no	Difficulty Breathing	yes	no	Radiation Therapy			
yes	no	Osteoporosis	yes	no	Rheumatic Fever			
yes	no	Epilepsy	yes	no	Seizures			
yes	no	Fainting Spells	yes	no	Sinus Problems/			
yes	no	Frequent Headaches			Hay Fever			
yes	no	Gag Reflex - Strong	yes	no	Stroke			
yes	no	Glaucoma	yes	no	Thyroid Problems			

Height _____ Weight _____

Women:

Are you pregnant? ❑ Yes ❑ No Due Date _____

Are you nursing? ❑ Yes ❑ No

Do you use tobacco? ❑ Yes ❑ No

Type/Usage _____

How much Alcohol per week? _____

How much Caffiene per day? _____

Do you use Recreational Drugs ❑ Yes ❑ No

MEDICATIONS

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

_____

_____

_____

Pharmacy Name _____

Phone (___)_____

ALLERGIES

❑ Aspirin	❑ Latex
❑ Codeine	❑ Metals
❑ Dental Anesthetic	❑ Penicillin
❑ Erythromycin	❑ Tetracycline

❑ Other _____

6 HIPPA/CONSENT (Consent for Purposes of Treatment, Payment & Healthcare Operations)

In this document, "I" and "my" refer to the patient, and "Dentist" refers to Designer Dentistry & Smiles.

I have been provided with a copy of the Notice of Privacy Practices of Dentist and understand that I have a right that Notice's of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Dentist. The Notice of Privacy Practices for Dentist is also posted in the waiting room at 6100 W. 41st Street Suite 101, Sioux Falls, SD 57106. This Notice of Privacy Practices also describes by rights and duties of the Dentist with respect to my protected health information.

❑ By checking this box I hereby give the right to any pictures taken by Designer Dentistry & Smiles to be displayed within the office.

By signing below I acknowledge that I have read the above paragraphs, and that all the information that I have provided on this sheet is correct and accurate to the best of my knowledge.

_____ _____

Signature of Patient or Personal Represent | Printed Name of Patient | Date

Designer Dentistry & Smiles

6100 W 41st St Suite 101
Sioux Falls, SD 57106
Phone: 605.361.1900 Fax: 605.361.3599
Email: dds.info.smiles@gmail.com

SCHEDULED APPOINTMENTS _____

We ask for at least 48-hour advance notice for canceling or rescheduling an appointment. If proper notice is not received your account may be assessed a fee of $50 for every 30 minutes.

All cancellation fees must be paid prior to scheduling another appointment.

The treatment that is planned for you is specific to you. It is important for you to keep the scheduled dates and times to properly complete your treatment. A broken appointment is a loss to three people; the patient who missed the valuable time, the patient who could have taken the valuable time, and the doctor who was fully staffed and prepared for the appointment.

PAYMENT POLICY _____

INSURANCE

We provide services for our patients with the understanding that they are responsible for payment in accordance with our financial policy. We will prepare and submit claims to assist you in obtaining the maximum benefits available from your dental insurance carrier. The dentist's treatment recommendations or fees are not affected by the presence or absence of insurance benefits. Treatment recommendations are based on your dental needs or desires and are not a reflection of your dental benefits. Your dental benefits are a contract between you, your employer, and the insurance company.

COLLECTIONS

In the event that your balance becomes more than 60 days overdue, billing may be turned over to an outside collection agency. The responsible party listed as the guarantor of the account agrees to pay interest, collection, and other legal expenses incurred relating to the collection of fees owed.

DOUBLE DENTAL GUARANTEE _____

We stand behind our work. Any basic restorative work such as fillings are under warranty for a period of 24 months. If they would need to be fixed or replaced for any reason we will do that at no charge. Any major work such as crowns or veneers are under warranty for 60 months against breakage or proper fit. Removable appliances such as retainers and dentures are under warranty for 12 months, labor only. You, the patient, are responsible for any lab bills associated with fixing an appliance that broke for any reason including dropping or putting in a pocket and sitting on it.

In order to keep your warranty in effect, you need to do your part by keeping recommended recall appointments including, but not limited to, an exam, cleaning, and x-rays. You are also required to brush and floss daily to prevent plaque build-up and dental decay from affecting your teeth and restorations. All custom dental work such as Somnomed, TruDenta, athletic mouth guards, occlusal guards, etc. are non-refundable.

Print Name: _____

Signature: _____ **Date:** _____

6100 W 41st St Suite 101
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35,000 new cases of oral cancer are diagnosed each year. The 5-year survival rate is only 50%. With early detection, you have a much better chance of surviving oral cancer. That is why we recommend anyone 15 years of age and older be screened annually.

Risk factors for developing oral cancer include smoking, chewing tobacco, alcohol consumption, and some strains of Human Papillomavirus (HPV). HPV is an increasingly common virus with approximately 6 million new cases per year.

We want to partner with you in beating cancer and keeping you healthy. In order to do that, we are now offering HPV screenings for the mouth and the Velscope oral cancer screening that allows us to catch cancer at its earliest stages.

☐ **Yes, please test me for cancer-causing HPV ($175)**

☐ **Yes, please include the Velscope screening with my exam today ($20)**

☐ **No, I am declining these potentially lifesaving tests at this time. I prefer a visual exam only.**

Print Name: _____

Signature: _____ **Date:** _____

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I,_____ understand that, under the Health Insurance Portability and Accountability Act of 1988 (HIPAA), I have certain rights to privacy regarding my protected health information.

I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received and read your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Print Name: _____

Signature: _____ **Date:** _____

HIPAA NOTICE OF PRIVACY PRACTICES

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us, whether electronically, on paper, or orally, are kept confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we maintain the privacy of your health information and how we may use and disclose this information. We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- Treatment means providing coordination or managing health care and related services by one or more health care providers. An example of this would include sharing x-rays with a referred specialist or another provider of your choice.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health Care Operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, audit functions, cost-management analysis, and customer service. An example of this would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

The following are your rights to your protected health information.

- The right to request restrictions on certain disclosures of protected health information, including those related to disclosures to family members, relatives, personal friends or any other person identified by you. We are not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it (except in an emergency).
- The right to reasonable requests to receive confidential communications of protected health information fro us by alternative means or at alternative locations. (Requests must be in writing).
- The right to inspect and copy your protected health information. (Request must be in writing).
- The right to amend your protected health information. (Request must be in writing and explain why the information should be amended).
- The right to receive an accounting of disclosures of protected health information for the last six years, but not before April 14, 2003.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of the revised Notice of Privacy Practices from this office.

You have recourse if you feel your privacy protections have been violated. You have the right to file a written complaint with our office, the Department of Health & Human Services, or the Office of Civil Rights about violations of provisions of the notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

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EXAMINATIONS AND X-RAYS

I understand that the initial visit may require radiographs in order to complete the examination, diagnosis, and treatment plan.

DRUGS, MEDICATIONS, AND SEDATION

I have been informed and understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness, swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock. They may cause drowsiness and a lack of awareness and coordination, which can be increased by the use of alcohol or other drugs. I understand and fully agree not to operate any vehicle or hazardous devices for at least 12 hours or until fully recovered from the effects of the anesthetic medication and drugs that may have been given me in the office for my treatment. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection, pain, and potential resistance to effect treatment of my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives.

CHANGES IN TREATMENT PLAN

I understand that during treatment, it murres because of conditions found while working on teeth that were not discovered during the examination, the most common being coot canal therapy following routine restorative procedures. I give my permission to the Dentist to make any or all changes and additions necessary.

TEMPOROMANDIBULAR JOINT DYSFUNCTIONS (TMJ)

I understand that symptoms of popping, clicking, locking, and pain can intensify or develop in the joint of the lower jaw (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. However, symptoms of TMJ associated with dental treatment are usually transitory in nature and well tolerated by most patients. I understand that should the need for treatment arise, then I will be referred to a specialist for treatment, and the cost of which is my responsibility.

FILLINGS

I understand that care must be exercised in chewing on fillings during the first 24 hours to avoid breakage and tooth sensitivity is common after a newly placed filling.

REMOVAL OF TEETH (EXTRACTION)

I understand removing teeth does not always remove all infection if present and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, the spread of infection, dry socket, loss of feeling in my teeth, lips tongue, and surrounding tissue (paraesthesia) that can last for an indefinite period of time, or jaw fracture. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.

CROWN, BRIDGES, VENEERS, AND BONDING

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize that the final opportunity to make changes in my new crowns, bridge, or cap (including shape, fit, size, placement, and color) will be done before cementation. It has been explained to me that, in very few cases, cosmetic procedures may result in the need for future root canal treatment, which cannot always be predicted or anticipated. I understand that cosmetic procedures may affect tooth surfaces and may require modification of daily cleaning procedures.

DENTURES, COMPLETE OR PARTIAL

I realize that full or partial dentures are artificial, constructed of plastic, metal and or porcelain. The problems of wearing those appliances have been explained to me including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new denture (including shape, fit, size, placement, and color) will be “teeth in wax” try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost of this procedure is not included in the initial denture fee.

ENDODONTIC TREATMENT (ROOT CANAL)

I realize there is no guarantee that root canal treatment will save my tooth and that complications can occur from the treatment and that occasionally metal objects are cemented in the tooth, or extend through the root, which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy).

PERIODONTAL TREATMENT

I understand that I have a serious condition causing gum inflammation and/or bone loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including non-surgical cleaning, gum surgery, and/or extractions. I understand the success of treatment depends, in part, on my efforts to brush and floss daily, receive regular cleanings as directed, follow a healthy diet, avoid tobacco products, and follow other recommendations.

I understand that every reasonable effort will be made to ensure that my condition is treated properly, although it is not possible to guarantee perfect results. By signing below, I acknowledge that I have received adequate information about the proposed treatment, that I understand this information and that all of my questions have been answered to my satisfaction.

I had the opportunity to discuss any alternatives to this treatment with my dentist. All of my questions were answered to my satisfaction regarding such alternatives and their risks, benefits, and cost.

No guarantee or assurance has been given to me by anyone that the proposed treatment or surgery will cure or improve the condition(s) listed above.

Print Name: _____

Signature: _____ **Date:** _____