

## CONFIDENTIAL PATIENT REGISTRATION FORM

NAME: _____	DATE: _____
PREFERS TO BE CALLED: _____	
ADDRESS: _____	CITY: _____ STATE: _____ ZIP: _____
PHONE: (HOME) _____ (WORK) _____ (MOBILE) _____	
E MAIL: _____ HOW WOULD YOU PREFER TO BE CONTACTED? _____	
D.O.B.: _____ SEX: M F MARITAL STATUS: M S D W SPOUSES NAME _____	
SS# _____ STUDENT: Y N WHERE: _____	
OCCUPATION: _____ EMPLOYER NAME: _____	
EMPLOYER ADDRESS: _____ EMPLOYER PHONE: _____	
PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT: _____	
WHOM MAY WE THANK FOR REFERRING YOU? _____	
<b>INSURANCE COMPANY NAME:</b> _____ <b>GROUP #</b> _____	
POLICY HOLDER'S NAME: _____ D.O.B. _____ SS# _____	
POLICY HOLDER'S EMPLOYER AND ADDRESS: _____	
POLICY HOLDER'S RELATIONSHIP TO PATIENT: _____	
<b>SECONDARY INS. CO. NAME:</b> _____ <b>GROUP #</b> _____	
POLICY HOLDER'S NAME: _____ D.O.B. _____ SS# _____	
POLICY HOLDER'S EMPLOYER AND ADDRESS: _____	
POLICY HOLDER'S RELATIONSHIP TO PATIENT: _____	

### CONSENT FOR TREATMENT

To the best of my knowledge, all the preceding and forthcoming answers are true and correct. If I have any change in my health or medications, I will inform Dr. Burwell and his staff at my next appointment. If deemed advisable, I grant permission for my physician to be contacted for details and advice. I authorize Dr. Burwell or designated staff to take x-rays, study models, photographs or other diagnostic measures appropriate for a thorough evaluation and diagnosis. Upon such diagnosis, I authorize Dr. Burwell and designated staff to perform any treatment mutually agreed upon by me and to employ such assistance as required for proper care.

I agree to the use of anesthetics, sedatives and other medication as necessary. I understand that the use of anesthetic agents embodies certain risks. I understand that I can ask for complete recital of any possible complications.

I agree to assume all financial responsibility of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made.

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_

## CONFIDENTIAL MEDICAL/DENTAL HISTORY - FOR OFFICE USE ONLY

The thoroughness of this medical history is designed for your safety. Your complete answers will assist us in treating your needs.

YOUR CURRENT PHYSICAL HEALTH IS: GOOD FAIR POOR YOUR LAST PHYSICAL EXAM WAS: \_\_\_\_\_  
PHYSICIANS NAME AND PHONE NUMBER: \_\_\_\_\_

Please use the back of this sheet should you need additional room to answer the following Y/N questions.

- Y N Have you been hospitalized within the past 2 years? If so, for what? \_\_\_\_\_  
Y N Are you currently being treated by a physician? If so, for what? \_\_\_\_\_  
Y N Are you currently taking any drugs or medications? If so, which ones and for what? \_\_\_\_\_  
\_\_\_\_\_
- Y N Are you allergic to any drugs? If so, which ones? \_\_\_\_\_  
Y N Have you had a skin rash or other reaction to metal jewelry? \_\_\_\_\_  
Y N Do you prefer non-metal restorations? \_\_\_\_\_  
Y N Do you bleed excessively upon injury or have been told that you are a hemophiliac?  
Y N Are you pregnant, on birth control or are you nursing a child?  
Y N Have you had joint replacement?  
Y N Have you had radiation to the head and or neck?  
Y N Do you experience chest pains or shortness of breath upon exertion?  
Y N Do you experience swollen ankles?  
Y N Do you smoke cigarettes? If so, how many per day? \_\_\_\_\_ How many years have you been smoking? \_\_\_\_\_  
Y N Have you ever been told that you have TMJ or have you experienced jaw joint pain or popping?  
And/or do you clench or grind your teeth? \_\_\_\_\_  
Y N Have you ever taken medications for weight control? If so, which ones? \_\_\_\_\_  
Y N Have you ever been advised to take antibiotics prior to dental treatment? If so, why? \_\_\_\_\_  
Y N Are you being treated for osteoporosis? If so, how? \_\_\_\_\_

### CIRCLE ANY OF THE FOLLOWING CONDITIONS THAT YOU HAVE HAD

ARTHRITIS	EPILEPSY	HIGH BLOOD PRESSURE	STROKE
ASTHMA	GLAUCOMA	LOW BLOOD PRESSURE	PACEMAKER
CANCER	HEART MURMER	KIDNEY PROBLEMS	HEPATITIS
DIABETES	HEART PROBLEMS	RHUEMATIC FEVER	HIV/AIDS
TUBERCULOSIS	LATEX ALLERGY	THYROID CONDITION	
SEXUALLY TRANSMITTED DISEASES	LIVER DISEASE	RECENT CHEMOTHERAPY	
	MITRO VALVE PROLAPSE		
	OTHER: _____		

WHAT PROMPTED YOU TO CALL FOR AN APPOINTMENT? \_\_\_\_\_

WHAT DO YOU HOPE TO ACCOMPLISH FROM TODAYS VISIT? \_\_\_\_\_

TO MAKE YOUR VISIT AS PLEASANT AS POSSIBLE, ARE THERE ANY PROBLEMS, ISSUES OR CHALLENGES YOU WOULD LIKE US TO KNOW? \_\_\_\_\_

WHAT IS THE TIME, ECONOMIC OR OTHER CONSIDERATIONS YOU WILL WANT US TO UNDERSTAND? \_\_\_\_\_

ARE YOU SATISFIED WITH THE APPEARANCE OF YOUR TEETH? IF NOT, WHAT IS IT THAT YOU WOULD LIKE TO CHANGE? \_\_\_\_\_

HAVE YOU EVER CONSIDERED WHITENING OR STRAIGHTENING YOUR TEETH? \_\_\_\_\_

WHAT ELSE WOULD YOU LIKE US TO KNOW BUT DID NOT ASK? \_\_\_\_\_

Robert M. Burwell, D.D.S.  
Notice of Privacy Practices

This notice describes how your health information may be used and disclosed and how you can access this information.

At Dr. Burwell's office, we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, give you this notice and follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor of whom we may involve in your care.

We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your health information into our computer.

We may share your medical information with our business associates, such as our accountant and dental laboratory. We have a written contract with each business associate that requires them to protect your privacy.

We may use information to contact you. For example, we may send a newsletter or other document. We may also call to remind you of your appointments. If you are not at home, we may leave information on your answering machine regarding your appointment or the person whom answers the phone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We may release some or all of your information when required by law.

If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.

You have the right to transfer copies of your health information to another practice. We will mail your files for you.

You have the right to see and receive a copy of your health information, with few exceptions. A written request is required to obtain information you want to see. If you want a copy of your records, we may charge you a reasonable fee for the copies.

You have the right to request an amendment or change to your health information. A written request to make changes is required. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

You have a right to receive a copy of this notice.

If we change any of the details of this notice, we will notify you of the changes in writing.

You may file a complaint with the Dept. of Health and Human Services, 200 Independence Avenue, S.W., Room 509F Washington DC 20201. You will not be retaliated against for filing a complaint.

Before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our office at (909) 621-0563.

This notice goes into effect as of April 14, 2003

**Robert M. Burwell, D.D.S**  
Acknowledgement of Receipt of Notice of Privacy Practices

You may refuse to sign this acknowledgement

By signing this form, I acknowledge that I have received and reviewed a copy of the Notice of Privacy Practices for the office of Robert M. Burwell, D.D.S., as required by law.

\_\_\_\_\_  
(Please print first and last name of patient)

\_\_\_\_\_ (please circle) patient/guardian  
(Signature)

\_\_\_\_\_  
(Date)

## **FINANCIAL OPTIONS**

To accommodate all of your financial obligations, we accept a variety of payment methods for your dental treatment. Let us work with you to personally choose a financial option that fits best with your personal budget.

### **CASH AND CHECK**

We accept cash and check and will offer a pre-payment courtesy if you pay in full before treatment begins by cash or check for treatment totals which exceed \$1000. (Contracted insurance plans excluded. Example: Delta Dental)

### **CREDIT CARDS**

We accept VISA, MasterCard, Discover and American Express. We apologize that we cannot offer a pre-payment courtesy when using a credit card.

### **LOW MONTHLY PAYMENT PLANS**

We work with financial partner CareCredit. CareCredit offers no interest and low interest payment plans with low finance fees for up to 60 months. Apply online at [CareCredit.com](http://CareCredit.com) or call (800) 365-8295

### **SENIOR COURTESY**

We offer a 5% senior courtesy on all treatment. Patients eligible for more than one courtesy will be limited to 5%. We apologize that we cannot offer a senior courtesy when using a credit card, CareCredit or Delta Dental insurance.