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DENTAL IMPLANT CENTER
your smile specialists

Registration Form

Today's Date:

PATIENT INFORMATION

☐ Mr.	☐Ms.	Patient Name:	
☐Mrs.	☐Dr.		
Address:			
City:		State:	Zip Code:
Phone:	Home:	Work 1:	Preferred Number called:
	Cell:	Work 2:	
Email:			
DOB:	Sex: ☐ Male ☐ Female		Marital: ☐Single ☐Married ☐Divorced ☐Widowed
Age:	SSN:		
Spouse or Contact Individual Name:			Phone:

Referred by:	Dentist/Office:	Website	Google Search	Mailer	Television
	Family/Friend:	Facebook Page / Ads	Instagram	YouTube	Other:
Preferred Pharmacy:	Address or Cross Streets:			Pharmacy Phone Number:	

DENTAL INSURANCE INFORMATION

(Please give your dental insurance card and driver's license to the receptionist)

Please indicate primary insurance:

Subscriber's name:	Subscriber's SSN:	Subscriber's DOB:	Group no:	ID/Member no:
Occupation:	Employer:	Employer address:	Employer phone no:	
Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other				
Name of secondary insurance (if applicable):	Subscriber's name:	Group no:	ID/Member no:	
Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other				

IN CASE OF EMERGENCY

Emergency Contact:	Relationship to patient:	Home/Mobile phone:	Work phone:
Do you authorize Revive Dental Implant Center to discuss your information with the above person? ☐ Yes ☐ No			

The above information is true to the best of my knowledge. I understand that I am financially responsible for any balance. I also authorize Revive Dental Implant Center or insurance company to release information required to process my claims. I consent to the initial examination and any radiographs (x-rays) that may need to be taken for diagnostic purposes.

Patient/Guardian signature:	**Date**

MEDICAL HISTORY FORM

Patient Name: _____

Medical Doctor: _____

Phone Number: _____

Allergies to:	
Latex:	☐ Yes ☐ No
Penicillin:	☐ Yes ☐ No
Other:	☐ Yes ☐ No

Under Physician's care **Yes** **No**

PreMed required? **Yes** **No**

Reason:_____

_____

Type:_____ Dosage:_____

Past and Current Medical Conditions (please mark Yes or No):

	YES	NO
AIDS/ HIV positive		
Alcohol or chemical dependency		
Anemia		
Artificial heart valves		
Artificial joints -Joint _____ Year _____		
Arthritis or other joint disorder		
Asthma		
Autoimmune Disease _____		
Bisphosphonate use (Fosamax, Actonel, etc.) When & Type?		
Bleeding problems		
Blood thinners/Aspirin Therapy		
Cancer		
Cerebral Palsy		
Chemotherapy		
Convulsions		
Depression:		
Diabetes Type Controlled? Y/N		
Dialysis		
Eating Disorder		
Emphysema		
Epilepsy/ Seizures		
Fainting/ Dizziness		
Fibromyalgia		
Glaucoma		
Headaches		
Head/ Neck/ Mouth injuries		
Heart Murmur		
Heart trouble/ disease		
Heart surgery		
Hemophilia		
Hepatitis If yes, **A** **B** **C**		

	YES	NO
High Blood Pressure -If yes, what is your normal pressure_____		
History of organ transplants		
Hospitalization/ operation(s) in last 5 years Details:		
Immunological disease		
Indwelling defibrillator		
Kidney disease		
Leukemia		
Lung disease		
Mitral valve prolapse		
Neurologic disease		
Other Psychiatric disorder		
Osteoporosis		
Pacemaker		
Past use of Fenphen		
Radiation Treatment to head/ neck		
Rheumatic Fever		
Shortness of Breath		
Sinus Trouble		
Sjogrens disease		
Sleep apnea		
Stomach: reflux ulcer		
Stroke		
Tobacco user If yes, type _____ - Amount: _____ # of Years _____		
Thyroid disease		
Tuberculosis		
Venereal disease		
Women: Nursing		
Women: Oral contraceptive		
Women: Pregnant		

Current Medications (Prescription, over the counter and Herbal)

MEDICATION	DOSAGE	FREQUENCY	REASON

DENTAL INFORMATION:

Current Dentist:	Previous Dentist
What made you decide to make this dentist appointment?	
Explain you past dental history?	

CONSISTENT DENTAL PROBLEMS WITH (please mark Yes or No):

	YES	NO		YES	NO
Loose teeth			Are you self-conscious about your teeth		
Difficulty chewing			Do you have jaw pain		
Teeth/ filling break frequently			Clenching or grinding habits		
Food catches between teeth			Sensitive teeth? Hot/Cold/Pressure/Sweets		
Do you have dentures &/or partial dentures			Do you hear popping/clicking/snapping		
Do you already have dental implants			Are you aware of any swelling or lumps		
Do you like how your teeth look			Sore/ bleeding gums		

Patient Signature: _____ ***Date:*** _____

Doctor Signature: _____ ***Date:*** _____

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Dental Consent Form

All patients receiving dental treatment will be asked to sign consent forms. Please review and sign consent before beginning treatment.

State law requires that you be given certain information and that we obtain your consent prior to beginning any treatment. What you are being asked to sign is a confirmation that we will discuss the nature and purpose of the treatment and the known risk associated with the treatment; that you will be given an opportunity to ask questions and that all questions are answered in a satisfactory manner. Please read this form carefully before signing it and ask about anything that you do not understand. We will be pleased to explain.

CONSENT FOR DENTAL TREATMENT

I hereby authorize Dr. Kent Howell, DMD, MS, or Dr. Nate Farley, DDS, MS, FACP, with the help of his staff to perform any dental treatment that we have discussed and agreed upon. I trust his expertise and dental knowledge.

IMPORTANCE OF PATIENT COMPLIANCE

I agree and understand that the degree of success of any dental treatment, including maintenance and hygiene, is directly related to my cooperation and that, if I fail to cooperate as requested and instructed, I may suffer temporary or permanent injury to my dental health, general health and/or to the dental work performed by my dentist. I agree to return for my regular scheduled visits as specified by the doctor for follow up checks to assure proper oral health. If evidence of pain, swelling, or inflammation should occur, I agree to notify Dr. Kent Howell, DMD, MS, or Dr. Nate Farley, DDS, MS, FACP, immediately.

RISK ASSOCIATED WITH NO TREATMENT

I understand that should I **not** proceed with dental treatment any current problems may progress. Some may lead to irreversible damage to teeth and/or oral hard and soft tissue.

I hereby state that I have read and fully understand this consent form, that I give my consent for an initial exam and diagnostic procedures that may be needed to determine any further treatment that may be necessary.

Patient Signature: _____ ***Date:*** _____

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DENTAL INSURANCE POLICY

As a courtesy to you, we will assist you in filing for your insurance benefits. To avoid any confusion, please be aware of the following facts:

1. We are a specialty office and are NOT contracted or in-network with your insurance.
2. Please understand that we file dental insurance as a courtesy to our patients. We are not responsible for how your insurance company handles its claims or what benefits they pay on a claim.
3. We can only assist you in estimating your portion of the cost of treatment.
4. At NO TIME do we guarantee what your insurance will or will not do with each claim.
5. We also cannot be responsible for any errors in filing your insurance; once again, we file claims as a courtesy to you!
6. Dental insurance is meant to be an aid in receiving dental care. Many patients think that their insurance pays 90% – 100% of all dental fees. THIS IS NOT TRUE! Most plans only pay between 50% – 80% of the average total fee. Some pay more; some pay less. The percentage paid is usually determined by how much you or your employer paid for coverage or the type of contract your employer has set up with the insurance company.
7. Most importantly, please keep us informed of any insurance changes regardless of how insignificant the change may seem. Many times, benefits change yearly as your contract renews or if you have a change in employment (even if it is the same insurance company). Your dental insurance coverage is dependent on how it is acquired. You should check with your employer's human resources department, your insurance carrier, or the representative/company who sold you the policy (meaning if it was privately purchased not through an employer) to verify any changes to your benefits.
8. Since we are an out of network provider, all explanations of benefits "EOB" will be mailed to you; please keep us informed, especially if you would like us to submit a claim to your secondary dental insurance.
9. We want to make this an easy process for you, and we would be more than happy to assist you with any questions that arise.

Patient Signature: _____ ***Date:*** _____

Revive Dental Implant Center

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI (PROTECTED HEATH INFORMATION) DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

_____ _____

Please ***print*** name of Patient | Please ***sign*** for Patient / Guardian of Patient

_____ _____

Legal Representative / Guardian | Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents: _____

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:
☐ First Name Only ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step-parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation
☐ Work Phone Confirmation
☐ Home Phone Confirmation
☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation
☐ Work Phone Confirmation
☐ Home Phone Confirmation
☐ **Any of the Above**

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

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PHOTOGRAPHY/VIDEO RELEASE

As specialists in restorative dentistry, Dr. Howell and Dr. Farley use dental photography to improve the care and quality they can provide their patients. While the main purpose in these routine photos is to manage and improve your care, there are some other times these photos are useful.

TEACHING Both Dr. Howell and Dr. Farley teach multiple continuing education (CE) courses and online webinars to dentists locally, nationally, and internationally. All of this is possible due to the kind patients we see here and their willingness to give consent for us to share photos of their new smiles. Patient names are never disclosed, and any facial photos have facial features covered to protect identity. We would ask that you consider giving us consent to use photos of your treatment (if taken) to help other dental students, dental technicians, and dentists improve their patients' care.

MARKETING Revive Dental Implant Center also uses photographs/videos in our marketing efforts to share with other current and potential patients the wonderful care we are providing here. This includes, but is not limited to, photos and/or videos used in printed and/or online/television advertising.

I hereby authorize Revive Dental Implant Center (Dr. Kent Howell and Dr. Nate Farley) to use photographs and videos taken of me for the following purposes (initial each you are authorizing):

_____ TEACHING (see above)

_____ MARKETING (see above)

_____ I do not want to allow the use of my photographs/videos for teaching or marketing purposes.
(We would still take photographs/videos, but only use them for your treatment)

By authorizing use of my photographs and/or videos, I acknowledge this participation is voluntary and therefore I will not receive financial compensation of any type. I acknowedge and agree that publication of photographs confers no rights of ownership or royalties whatsoever.

I understand I will not have an opportunity to view/hear pictures, video, or audio materials prior to their release.

I hereby release and hold harmless Revive Dental Implant Center (Dr. Kent Howell and Dr. Nate Farley) from any reasonable expectation of privacy or confidentiality associated with the images specified above.

_____	_____	_____
Printed Name (Patient or Guardian)	Signature (Patient or Guardian)	Date
_____	_____	_____
Printed Name (Witness)	Signature (Witness)	Date