ReGenesis Health Care
Family Dentistry

PATIENT REGISTRATION FORM

Patient Name _____ **Date of Birth** _____ **Age** _____
Last First Middle

Sex ☐Male ☐ Female **Social Security #**_____

Mailing Address _____Apt/Suite _____
City _____ State _____ Zip Code_____

Phone #_____ Cell #_____ Best way to reach you? ☐Home ☐ Cell

Marital Status ☐Single ☐ Married ☐ Divorced ☐Separated ☐Widowed ☐ Other _____

Emergency Contact _____ Phone # _____
Relationship to Patient _____

Ethnic Group ☐ American ☐ Indian/Alaska Native ☐Asian ☐ Black/African-American ☐Hispanic
☐Latino ☐Native Hawaiian ☐Other Pacific Islander ☐Refused to Report ☐ White

Language: ☐English ☐Sign Language ☐Spanish ☐Other(Please list language)_____

Characteristics: ☐Migrant Worker ☐Seasonal Worker ☐Homeless ☐ Homeless Shelter
☐Transitional/Visiting ☐Multiple Family Household ☐Unknown ☐ Other_____

Referral Source (How did you hear about us?): ☐Health Fair/Event ☐Relative/Friend ☐Newspaper ☐Internet
☐Phone Book ☐Word of Mouth ☐Hospital/Agency/Physician _____
Name of hospital/agency/physician

For Informational Purposes Only
Annual Household Income _____ Family Size ___ Are you a veteran? ☐Yes ☐ No

PATIENT(PARENT/GUARDIAN) EMPLOYMENT INFORMATION

Employment Status: ☐Full-time ☐Part-time ☐ Unemployed ☐Retired ☐ Seasonal ☐ Migrant
Student: ☐Full-time ☐ Part-time
Employer _____
Address _____
City/State _____ Zip Code _____
Employer Phone # _____ Can we contact you at work: ☐Yes ☐ No

PATIENT(PARENT/GUARDIAN) INSURANCE INFORMATION

*Co-payments are required at time of visit and/or payment for services not covered by insurance.

☐ Private Insurance ☐ Self Pay ☐ Workers Comp ☐ Disabled ☐ Other
☐ Medicare#_____ ☐ Medicaid# _____
Insurance Company_____ Insured's Name _____
Group#_____ Policy#_____
SS#_____ DOB_____
Employer _____ Employer Phone #_____

*I authorize the release of any required medical information from my record to the above insurance company in order to process my claim.

_____
Signature of Patient, Guardian or Legal Representative /Date

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GENERAL CONSENT TO TREAT/
PATIENT AUTHORIZATION/ACKNOWLEDGEMENT OF BENEFITS RELEASE

The following are the conditions for services provided by ReGenesis Health Care Family Dentistry for the patient whose signature appears at the bottom of this page.

CONSENT FOR DENTAL TREATMENT
I voluntarily consent to dental treatment and diagnostic procedures provided by ReGenesis Health Care Family Dentistry and its associated dentists and other personnel. I am aware that practice of dentistry is not an exact science and I acknowledge that no guarantee has been made to the result of treatments and examinations.

AUTHORIZATION FOR RELEASE OF DENTAL AND MEDICAL INFORMATION
ReGenesis Health Care is authorized to release any dental and or medical information required in the processing of applications or submission of information for financial coverage and further dental treatment. I also agree to the release of dental/medical and or other information about me to federal government or state regulatory agencies as required by law.

ASSIGNMENT OF INSURANCE BENEFITS
I guarantee payment of all charges made for or on account of the patient and I assign my rights in any insurance benefits or other funding to ReGenesis Health Care Family Dentistry. I understand that I am responsible for any charges not covered by insurance or other forms of benefits.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT
I have received or read a copy of the Notice of Privacy Practices The notice describes how my health information may be Used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time. The Notice of Privacy Practices may be accessed at *www.myrhc.org.*

_____ _____
Signature of Patient, Guardian or Legal Representative *Date*

If signed by other than patient, relationship to patient: _____

Witness(Personnel)_____ _____
Date

**This organization is required to maintain the privacy and confidentiality of your health information and provide you with a notice as to our legal duties and privacy practice with respect to information we collect and maintain about you.*

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PARENT/GUARDIAN INFORMATION

Name & Relationship of Adult Accompanying Child_____

List of persons having permission to obtain medical treatment for your child if you are unable to accompanyy your child. Person must provide photo identifaction at time of visit for your child to be seen.

Name:_____ Relationship:_____
Name:_____ Relationship:_____

ReGenesis Health Care Family Dentistry will only communicate information regarding your care, or that of a minor child to those individuals that you have authorized. Please list below the names of any relatives, as well as their relationship to you, that you authorize Regenesis Health Care Family Dentistry to communicate with regarding your care.

I AUTHORIZE THE SHARING OF MY MEDICAL/DENTAL INFORMATIONWITH THE FOLLOWING INDIVIDUALS

Name: _____ Relationship_____

Name: _____ Relationship_____

Patient(Parent/Guardian) Signature_____ Date_____

How would you like to be contacted regarding appointments, treatment, or other information pertaining to your care?

_____Mail _____Home Phone _____Work Phone

If you do not authorize the use of any of these methods, them please list any alternate method we may use in contacting you:
_____
_____
_____

Patient(Parent/Guardian) Signature: _____ Date_____

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In order for us to continue to serve you and your family's Dental needs, we ask that you abide by our payment policy.

1. Payment is due and payable at the time the service is rendered. Any other arrangements must be made with the business office manager, or designee, prior to being seen.
2. ReGenesis Health Care Family Dentistry reserves the right to control appointments until financial arrangements have been made.
3. ReGenesis Health Care Family Dentistry will file insurance claims with only certain insurance carriers. The business office will discuss your policy with you at the time of your first visit. Proof must be provided to show that your deductible has been met. Depending up on your particular insurance company, a co-payment may be required at the window.
4. ReGenesis Health Care Family Dentistry is not responsible for follow-up with insurance carriers. If payment from the insurance carrier has not been received within 45 days of filing, the responsible party will then receive a statement that payment will be expected within 15 days.
5. Patients qualifying for our discount sliding fee program are responsible for payment in full for specialty services or rates that have been set on a sliding fee scale for specialty services.

The undersigned hereby acknowledges to have read and agrees with the above payment policy of ReGenesis Health Care Family Dentistry.

_____	_____	_____
Signature	Date	Relationship to Patient

ReGenesis Health Care
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Patient Name_____ Date of Birth_____

Family History

Females Only

Last Delivery Date:_____
Menses: Regular:_____
Menses: Irregular:_____
Last Menstrual Period:_____
No. of Pregnancies:_____
No. Living Children:_____

Social History

Single_____ Married_____
Separated_____ Divorced_____

Do you smoke? _____
How many per day? _____
How many years? _____
Do you drink alcohol? _____
How many drinks per week? _____

Allergies

	Yes	No
None Known	☐	☐
Penicillin	☐	☐
Sulfa	☐	☐
Local Anesthetics	☐	☐
Aspirin	☐	☐
Codeine	☐	☐
Acrylic	☐	☐
Metal	☐	☐
Latex Rubber	☐	☐
Other Antibiotic	☐	☐
Acetaminophen/Tylenol	☐	☐

Other_____
_____
_____

Past Illness- Self

Have you had or presently have any of these problems?

	Yes	No
Artificial Joints/Plates/Pins	☐	☐
Diabetes	☐	☐
Tuberculosis	☐	☐
Cancer/Chemotherapy	☐	☐
Epilepsy (seizures)	☐	☐
Rheumatic Fever	☐	☐
German Measles	☐	☐
Jaundice (yellow)	☐	☐
Phlebitis (Blood Clot)	☐	☐
Nervous Problem	☐	☐
High Blood Pressure	☐	☐
Low Blood Pressure	☐	☐
Anemia-Blood Disease	☐	☐
Blood Transfusion	☐	☐
Asthma/Hay Fever	☐	☐
Cholesterol	☐	☐
Venereal Disease	☐	☐
HIV/AIDS	☐	☐
Peptic Ulcer/Stomach	☐	☐
Gout	☐	☐
Heart Surgery /Disease	☐	☐
Mitral Valve Prolapsed	☐	☐
Congenital Heart Disorder	☐	☐
Heart Attack/Heart Pacemaker	☐	☐
Angina/Chest Pain Disorder	☐	☐
Irregular Heartbeat/Murmur	☐	☐
Arthritis	☐	☐
Autism	☐	☐
Whooping Cough	☐	☐
Mumps	☐	☐
Glaucoma	☐	☐

Past Illness-Self (continued)

	Yes	No
Excessive bleeding	☐	☐
Sickle Cell Disease	☐	☐
Liver Disease	☐	☐
Hepatitis A, B, C	☐	☐
Drug Addiction	☐	☐
Kidney Problems	☐	☐
Psychiatric Care	☐	☐
Thyroid Disease	☐	☐
Alzheimer's Disease	☐	☐
Hemophilia	☐	☐

Other not listed_____
_____
_____

Previous Surgery

Tonsils	☐	☐
Appendix	☐	☐
Gall Bladder	☐	☐
Hernia	☐	☐
Breast	☐	☐
Hysterectomy	☐	☐
Tubal Ligation	☐	☐
Caesarean Section	☐	☐
D & C		

Other_____
_____
_____

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Patient's Name_____ Date_____

Primary reason for dental appointment ☐ Examination ☐ Emergency ☐ Consultation

Dental History	**Yes**	**NO**
Do you have a specific dental problem? Please describe:	☐	☐
Do you have dental examinations on a routine basis? Last visit:	☐	☐
Do you think you have active decay or gum disease?	☐	☐
Do you brush and floss on a routine basis? Discuss:	☐	☐
Do your gums ever bleed? Discuss:	☐	☐
Do you like your smile? Why?	☐	☐
Does food catch between your teeth? Any loose teeth?	☐	☐
Do you want to keep your remaining teeth?	☐	☐
Do you ever have clicking, popping or discomfort in the jaw joint? Do you grind?	☐	☐
Have your past experiences in a dental office always been positive?	☐	☐
Do you smoke or chew? Any sores or growths in your mouth? Discuss:	☐	☐
Name of previous dentist? (Optional)	☐	☐
Have you ever had x-rays taken? Date of last full mouth x-rays:	☐	☐

Medical History	**Yes**	**NO**
Are you under a physician's care now? Why?	☐	☐
Have you ever been hospitalized or had a major operation? Discuss:	☐	☐
Have you ever had a serious injury to your head or neck? Discuss:	☐	☐
Are you on a special diet? Discuss:	☐	☐
Women (Please Check) ☐Pregnant/trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives Discuss:	☐	☐
Do you wish to talk to the dentist privately about any problem?	☐	☐

To the best of my knowledge, all of the preceding answers are correct. If I have changes in my health status or if my medications change, I will inform the dentist and staff at the next appointment without fail.

_____ Date_____

Patient Signature (Parent or Guardian)

Reviewed by Doctor_____ Date_____

History review and significant findings_____

_____

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Medication List

Name:	**Date of Birth:**
Pharmacy:	**Phone:**

Allergic To/Describe Reaction:	**Allergic To/Describe Reaction:**

List all prescription and over-the-counter (non-prescription) medications such as vitamins, Aspirin, Tylenol, and herbals (ex: Ginseng, Gingko Biloba, St. John's Wort) Include prescription meds taken as needed, (ex. Viagra, Nitroglycerin.)

Date	**Name of Medication/Dose**	**Directions: Use patient friendly Directions. Do not use medial Abbreviations.**	**Date Stopped**	**Reason for taking/MD name**

Date last received the following:

IMMUNIZATION RECORD (Record the last dose taken)
TETANUS
PNEUMONIA VACCINE
FLU VACCINE
HEPATITIS VACCINE

Dental Office Location: 550 South Church Street
Spartanburg, SC 29306
Office: (864) 398-4185
Fax:(864) 573-7701