



David Bates, DDS

Thank you for choosing our practice! We look forward to taking care of all your dental needs. Please fill out this form in ink. If you have any questions regarding this form, we are happy to help!

**Patient Registration Form: (Please fill out completely)**

Date: \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

**Patient Information:**

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

Preferred Name: \_\_\_\_\_ Email Address: \_\_\_\_\_

Billing Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Mobile #: \_\_\_\_\_ Home #: \_\_\_\_\_ Work #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M F Marital Status: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ College Student (Full time) School Name: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_  
(Name) (Relation) (Phone #)

**Responsible Party Information: (Must be completed if different from patient information)**

Last Name: \_\_\_\_\_ First Name and MI: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

Billing Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Mobile #: \_\_\_\_\_ Home #: \_\_\_\_\_ Work #: \_\_\_\_\_

**Dental Insurance Information:**

Primary Dental Insurance Company Name: \_\_\_\_\_ Employer: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

Group #: \_\_\_\_\_ Subscriber ID: \_\_\_\_\_ Claim Phone #: \_\_\_\_\_

Claim Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Secondary Dental Insurance Company Name: \_\_\_\_\_ Employer: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

Group #: \_\_\_\_\_ Subscriber ID: \_\_\_\_\_ Claim Phone #: \_\_\_\_\_

Claim Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

**Patient/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

# Health History Form

Email: \_\_\_\_\_ Today's Date: \_\_\_\_\_

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: <i>Last First Middle</i>			Home Phone: <i>Include area code</i> ( )	Business/Cell Phone: <i>Include area code</i> ( )	
Address: <i>Mailing address</i>			City:	State:	Zip:
Occupation:	Height:	Weight:	Date of Birth:	Sex: M F	
SS# or Patient ID:	Emergency Contact:	Relationship:	Home Phone: <i>Include area code</i> ( )	Cell Phone: <i>Include area code</i> ( )	
If you are completing this form for another person, what is your relationship to that person?					
<i>Your Name</i>			<i>Relationship</i>		
<b>Do you have any of the following diseases or problems:</b>			<i>(Check DK if you Don't Know the answer to the the question)</i>		<b>Yes No DK</b>
Active Tuberculosis.....					<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Persistent cough greater than a 3 week duration.....					<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Cough that produces blood.....					<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Been exposed to anyone with tuberculosis.....					<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<b>If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.</b>					

## Dental Information *For the following questions, please mark (X) your responses to the following questions.*

Yes No DK	Yes No DK
Do your gums bleed when you brush or floss?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you have earaches or neck pains?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Are your teeth sensitive to cold, hot, sweets or pressure?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you have any clicking, popping or discomfort in the jaw?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Is your mouth dry?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you brux or grind your teeth?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Have you had any periodontal (gum) treatments?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you have sores or ulcers in your mouth?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Have you ever had orthodontic (braces) treatment?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you wear dentures or partials?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Have you had any problems associated with previous dental treatment?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you participate in active recreational activities?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Is your home water supply fluoridated?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Have you ever had a serious injury to your head or mouth?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Do you drink bottled or filtered water?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Date of your last dental exam:
If yes, how often? <i>Circle one:</i> DAILY / WEEKLY / OCCASIONALLY	What was done at that time?
Are you currently experiencing dental pain or discomfort?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Date of last dental x-rays:
What is the reason for your dental visit today?	
How do you feel about your smile?	

## Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

Yes No DK	Yes No DK
Are you now under the care of a physician?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Have you had a serious illness, operation or been hospitalized in the past 5 years?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Physician Name: _____ Phone: <i>Include area code</i> ( )	If yes, what was the illness or problem?
Address/City/State/Zip:	Are you taking or have you recently taken any prescription or over the counter medicine(s)?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Are you in good health?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:
Has there been any change in your general health within the past year?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	_____
If yes, what condition is being treated?	_____
Date of last physical exam:	_____

# Medical Information Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

*(Check DK if you Don't Know the answer to the question)*

Do you wear contact lenses? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Yes No DK	Do you use controlled substances (drugs)? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Yes No DK
<b>Joint Replacement.</b> Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Date: _____ If yes, have you had any complications? _____	Yes No DK	Do you use tobacco (smoking, snuff, chew, bidis)? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> If so, how interested are you in stopping? Circle one: VERY / SOMEWHAT / NOT INTERESTED	Yes No DK
Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Yes No DK	Do you drink alcoholic beverages? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> If yes, how much alcohol did you drink in the last 24 hours? _____ If yes, how much do you typically drink in a week? _____	Yes No DK
Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Date Treatment began: _____	Yes No DK	<b>WOMEN ONLY</b> Are you: Pregnant? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Number of weeks: _____ Taking birth control pills or hormonal replacement? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nursing? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	

**Allergies.** Are you allergic to or have you had a reaction to: To all **yes** responses, specify type of reaction.

Local anesthetics ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Yes No DK	Metals ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Yes No DK
Aspirin ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Yes No DK	Latex (rubber) ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Yes No DK
Penicillin or other antibiotics ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Yes No DK	Iodine ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Yes No DK
Barbiturates, sedatives, or sleeping pills ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Yes No DK	Hay fever/seasonal ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Yes No DK
Sulfa drugs ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Yes No DK	Animals ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Yes No DK
Codeine or other narcotics ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Yes No DK	Food ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Yes No DK
		Other ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Yes No DK

**Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.**

Artificial (prosthetic) heart valve ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Yes No DK	Autoimmune disease ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Yes No DK	Glaucoma ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Yes No DK
Previous infective endocarditis ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Yes No DK	Rheumatoid arthritis ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Yes No DK	Hepatitis, jaundice or liver disease ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Yes No DK
Damaged valves in transplanted heart ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Yes No DK	Systemic lupus erythematosus ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Yes No DK	Epilepsy ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Yes No DK
Congenital heart disease (CHD)	Yes No DK	Asthma ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Yes No DK	Fainting spells or seizures ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Yes No DK
Unrepaired, cyanotic CHD ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Yes No DK	Bronchitis ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Yes No DK	Neurological disorders ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Yes No DK
Repaired (completely) in last 6 months ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Yes No DK	Emphysema ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Yes No DK	If yes, specify: _____	Yes No DK
Repaired CHD with residual defects ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Yes No DK	Sinus trouble ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Yes No DK	Sleep disorder ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Yes No DK
Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.					
Cardiovascular disease ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Yes No DK	Tuberculosis ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Yes No DK	Do you snore? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Yes No DK
Angina ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Yes No DK	Cancer/Chemotherapy/ Radiation Treatment ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Yes No DK	Mental health disorders ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Yes No DK
Arteriosclerosis ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Yes No DK	Chest pain upon exertion ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Yes No DK	Specify: _____	Yes No DK
Congestive heart failure ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Yes No DK	Chronic pain ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Yes No DK	Recurrent Infections ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Yes No DK
Damaged heart valves ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Yes No DK	Diabetes Type I or II ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Yes No DK	Type of infection: _____	Yes No DK
Heart attack ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Yes No DK	Eating disorder ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Yes No DK	Kidney problems ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Yes No DK
Heart murmur ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Yes No DK	Malnutrition ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Yes No DK	Night sweats ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Yes No DK
Low blood pressure ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Yes No DK	Gastrointestinal disease ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Yes No DK	Osteoporosis ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Yes No DK
High blood pressure ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Yes No DK	G.E. Reflux/persistent heartburn ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Yes No DK	Persistent swollen glands in neck ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Yes No DK
Other congenital heart defects ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Yes No DK	Ulcers ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Yes No DK	Severe headaches/migraines ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Yes No DK
		Thyroid problems ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Yes No DK	Severe or rapid weight loss ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Yes No DK
		Stroke ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Yes No DK	Sexually transmitted disease ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Yes No DK
				Excessive urination ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Yes No DK

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? .....

Name of physician or dentist making recommendation: \_\_\_\_\_ Phone: *Include area code* ( )

Do you have any disease, condition, or problem not listed above that you think I should know about? .....     
 Please explain: \_\_\_\_\_

**NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.**

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Dentist: \_\_\_\_\_ Date: \_\_\_\_\_

**FOR COMPLETION BY DENTIST**

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



David Bates, DDS

### HIPAA- PATIENT ACKNOWLEDGEMENT FORM

Loop Dental's Notice of Privacy Practices (NPP) provides information about how we may use and disclose protected health information (PHI) about you. The practice provides this form to comply with the Health Insurance Portability and Accountability Act (HIPAA). The NPP contains a Patient Rights section describing your rights under the law. Please review the Notice of Privacy Practices thoroughly before signing this acknowledgement form. In the event that the terms of the Notice change, a revised copy will be made available to you.

By signing this form, you acknowledge that our Practice may use and disclose PHI about you for treatment, payment and office procedures. You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or office procedures.

I give permission for Loop Dental to leave a message or an email regarding an appointment at:

Home: \_\_\_\_\_ and/or

Cell: \_\_\_\_\_ and/or

Work: \_\_\_\_\_ and/or

Email: \_\_\_\_\_

I give permission for Loop Dental to share medical/dental information with:

1. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_

2. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_

3. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_

I assume responsibility to inform the practice of any changes in the above information.

Patient's Name (please print): \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Patient or Legal Guardian: \_\_\_\_\_

# FINANCIAL POLICY

## Assignment and Release

I, the undersigned, have insurance with \_\_\_\_\_, and assign directly to Loop Dental all 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits.

Date: \_\_\_\_\_

Signature: \_\_\_\_\_  
Signature of patient/parent/legal guardian

## Patient Agreement and Financial Policy

I hereby agree to be responsible for the costs of care provided by Loop Dental and/or the dental team for myself or my dependent(s). These include any deductibles and amounts not covered by insurance. **I also understand that it is my responsibility to be aware of any limitations, and benefits of my insurance policy.** Payment to this office is my responsibility and I am aware that if the insurance company does not reimburse the doctor, I am responsible for the total amount(s).

I understand that because appointments are not double-booked, I must provide notice of cancellation at least 48 hours prior to my scheduled appointment time. **There will be a \$50 fee applied to all appointments cancelled with less than 48 hours' notice. For appointments where major procedures are to be performed and are 90 minutes or more in length, a non-refundable reservation fee of \$100 will be required.**

We make every effort to schedule appointments that are most convenient for you and that fit your personal schedule. Because we do not schedule several patients at the same time, all appointments are reserved exclusively for you. In return, we ask that you make every effort not to change your reserved dental appointment.

I understand that for any treatment less than three hundred dollars (\$300) payment in full is due at the time of service. I understand that after 60 days, any unpaid balance will incur a \$10 billing fee. I understand that failure to pay amounts due to this office will result in my account being placed with a collection agency. In the event that my account is further referred to an attorney, I agree to pay all collection and attorney fees.

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

## Minor/Child Consent

I, being the parent or legal guardian of \_\_\_\_\_, do here, by request and authorize the dental staff to perform necessary services for my child, including but not limited to radiographs (x-rays) and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

Date: \_\_\_\_\_

Signature: \_\_\_\_\_  
Signature of patient/parent/legal guardian