Mclaurin Family Dentistry

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES ("Acknowledgement")

I, , have received a copy of the **HIPAA Notice of Privacy Practices** of this office.

Patient Name (Please Print)

Patient Signature or Representative Date

Authority of Personal Representative to sign for Patient (check one)
☐ Parent ☐Guardian ☐ Power of Attorney ☐Other_____

Please Note: It is your right to refuse to sign this acknowledgement.

Dental Office Use Only

We tried to obtain written acknowledgement by the individual noted above of receipt of our **Notice of Privacy Practices**, but it could not be obtained because:

An emergency prevented us from obtaining acknowledgement.

A communication barrier prevented us from obtaining acknowledgement.

The individual was unwilling to sign.

Other:

_____
Staff Member Signature

COLUMBUS FAMILY DENTISTRY

Scott McLaurin, D.M.D **Fred Moore, D.M.D.**

Date_____

Name_____Address_____

City_____State_____Zip_____

Home Phone_____***Cell Phone***_____Work_____

Date of Birth _____/_____/_____ Age_____ M____F___ Married____Single_____

Social Security _____-_____-_____ ***E-Mail***_____

Name of Employment_____

Emergency Contact: _____Phone_____

Whom May we thank for referring you?_____

Primary Dental Insurance Information

Policy Holder/Employee/Sponsor_____

Place of Employment_____

Date of Birth _____/____/_____ Insured ID#_____

Insurance Company Name_____Group #_____

Secondary Dental Insurance Information

Policy Holder/Employee/Sponsor_____

Place of Employment_____

Date of Birth _____/____/_____ Insured ID#_____

Insurance Company Name_____Group #_____

Columbus Family Dentistry

2200 Rosemont Drive Columbus GA 31904

(706)596-1895

columbusfamilydentistry@gmail.com

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Patient Registration Form

Name--_____

Address--_____

_____

By signing below I verify that all information given in this packet is true and correct to the best of my knowledge. I agree to be responsible for payment of all services rendered.

Your signature is necessary for us to insure payment for services rendered, to release medical information, and to release information to other medical/dental providers, when necessary, concerning your treatment.

I authorize the release of my medical and/or dental information, when necessary, to other providers rendering medical/dental care.

Signature_____ Date_____

Columbus Family Dentistry

2200 Rosemont Drive Columbus, GA 31904

(706)596-1895

columbusfamilydentistry@gmail.com

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Patient Registration for Children and/or Dependents

Patient's name-_____

Addres_____

_____

By signing below I verify that all information given in this packet is true and correct to the best of my knowledge. I agree to be responsible for payment of all services rendered. Important information about children with divorced/separated parents—the parent who brings the child to the office is responsible for payment of treatment rendered and is due and payable *at the time of service*. We will not bill the other parent.

Your signature is necessary for us to ensure payment for services rendered, to release medical information, and to release information to other medical/dental providers, when necessary, concerning your treatment.

I authorize the release of all medical and/or dental information, when necessary, to other providers rendering medical/dental care.

Signature of Parent or Guardian_____ Date_____

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____

Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____