DRS MOORE AND MOORE DENTAL
PATIENT REGISTRATION AND MEDICAL HISTORY

Patient_____
(Last) *(First)* *(MI)* *Preferred Name*

Male ____ **Female** ____ **Single** ___ **Married** ____ **Birthdate:**_____ **Age:**_____ **SS#** _____

Street Address_____ **City**_____ **State**_____ **Zip**_____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Email:_____ **Do you want to receive an appt reminder by email or text?** _____

Employed By:_____ **Occupation:**_____

Business Address: _____ **City**_____ **State**_____ **Zip**_____

*Spouse Name:*_____
(Last) *(First)* *(MI)* *Preferred Name*

*Spouse Birthdate:*_____ *SS#* _____ *Cell Phone:* _____

*Employed By:*_____ *Business Phone:*_____

Business Address: _____

Name of Dental Insurance Company _____
Subscribers ID # _____ Group # _____ Phone:_____
Previous Dentist Name:_____ Phone: _____
Address: _____ Last Visit: _____

YOUR MEDICAL HISTORY

In case of an emergency, who should be notified? _____ Phone: _____
Physicians Name:_____ Phone:_____
Have you ever had any of the following? (check only that apply):

Drug Allergies:

- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Circulatory Problems
- ☐ Clinical Anxiety
- ☐ Artificial Heart Valves or Joints
- ☐ Diabetes
- ☐ Respiratory Disease
- ☐ Epilepsy
- ☐ Headaches
- ☐ Cancer
- ☐ Psychiatric Care
- ☐ Blood Disease
  Specify:_____
- ☐ Arthritis
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Thyroid
- ☐ Stroke
- ☐ Hepatitis, Jaundice, Liver Disease
- ☐ Ulcers
- ☐ Venereal Disease (STD)
  Specify:_____
- ☐ Substance Dependency:
- ☐ Alcohol ___
- ☐ Drugs ____
- ☐ I am in rehab
- ☐ I smoke
- ☐ I use smokeless tobacco

List medications you are taking:_____

(Women) Are you or suspect you are pregnant?_____ If so, how far along are you? _____ Are you currently nursing?_____

Is there anything else we should know about your medical history?_____

Whom May We Thank For Referring You?_____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form and understand that ultimately I am responsible for the total amount of the procedures performed.

Signature:_____ Date: _____

CHILD REGISTRATION AND MEDICAL HISTORY

Date:_____ Home Phone_____

Patient_____
Last First MI Preferred

Address_____
Street City State Zip

Sex ___Male ___Female Age_____ Birthdate_____ Social Security #_____

Student Status _____Full Time ____Part-Time School_____

Previous Dentist_____ Last Seen_____

Physician's Name_____ Phone Number_____ Last Physical_____

Child's Weight_____(approximate) Whom may we thank for referring you?_____

Does the child have drug allergies? _____ If so, what?_____

Is the child taking any medication?_____If so, what?_____

For what conditions?_____

Under the care of a physician?_____For what?_____

Has your child had/has any of the following:

- ☐ Heart Problems
- ☐ High or Low Blood Pressure
- ☐ Artificial Heart Valves or Joints
- ☐ Heart Murmurs or Holes
- ☐ Blood Disease
- ☐ Epilepsy
- ☐ Hepatitis, Jaundice or Liver Disease
- ☐ Cancer
- ☐ Radiation Treatment
- ☐ Special Diet
- ☐ Diabetes
- ☐ AIDS or Other Immunosuppressive Disorder
- ☐ Other _____
- ☐ _____

PARENTS INFORMATION: **Contact preference regarding your childs appointment: email text cell home work (circle one or more)**

Parent's Name_____
Last First MI Relationship to Patient

Address_____
Street City State Zip

Social Security #_____Birthdate _____ _____Married ____ Single ____ Widowed ____ Divorced

Employed By_____Position_____Work Phone Number_____

Address_____State_____Zip_____

Cellphone: _____Home Phone:_____Email:_____

Spouse's Name_____
Last First MI Relationship to Patient

Address___Same as Above _____
Street City State Zip

Social Security#_____ Birthdate _____

Employed By_____Position_____Work Phone Number_____

Cellphone: _____Home Phone:_____Email:_____

DENTAL INSURANCE INFORMATION

Name of Dental Insurance Company_____ Group Number_____

Subscribers Name_____SS#_____Employer_____

Secondary Insurance Company_____ Group Number_____

Subscribers Name_____SS#_____Employer_____

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his staff responsible for any errors or omissions that I may have made n the completion of this form.

Date_____ Signature_____

DRS. MOORE & MOORE DENTAL ASSOCIATES

NOTICE OF PRIVACY PRACTICES

The privacy and security of your personal health information is very important to us. In compliance with the law, we must provide our patients a copy of the HIPPA regulations that describe how their health information may be used and disclosed and how they can get access to this information. Frequently, we may run Board of Pharmacy reports, obtain dental records or x-rays from previous dentists or contact your physician or OB to give you the highest level of treatment. A copy of these regulations are posted and are available to you at your request.

FINANCIAL POLICY

We accept cash, Visa, Mastercard, Discover and CareCredit

Payments for services are collected when treatment is rendered. These payments include but are not limited to insurance deductibles, estimated co-payments and prior balances for services rendered. The responsibility for payment for services to any dependent children whose parents are divorced rests with the parent/guardian who seeks the treatment.

We reserve the right to charge interest and fees on a balances more than 30 days past due.

CONCERNING YOUR INSURANCE

There are hundreds of insurance policies on the market, all having different premiums, deductibles, limits and maximums. Although we will try to help you whenever possible to receive your claim, *the agreement is between you and your insurance company and we cannot be responsible for the details of your plan and its limits.*

If you have Medicaid, you must present your current month's card

or you are responsible for the services performed.

We cannot guarantee payment of your claims.

By signing below, you authorize payment of the dental benefits otherwise payable to you directly to our office.

Please let us know if there are any changes to your insurance plan.

APPOINTMENTS

We will try our best to arrange appointments at your convenience. However, we do ask that you give us a 48-hour notice if you need to cancel or reschedule an appointment.

We may charge $50/hour for each broken appointment.

May we call your work number to confirm your appointment?..... Yes No
(we may need to leave a message on a voicemail)

Should someone call for your information, may we release limited information? Yes No

Preferred Appointment Reminder: (please circle one or more)

TEXT EMAIL CALL: CELL WORK HOME

By signing below I acknowledge that I have received a copy of Dr. Moore's notice of privacy practices, have read the above office policy and consent to treatment provided by Drs. Moore and Moore Dental Associates

Signature of patient/guardian **Date**

420 VIRGINIA STREET WEST • CHARLESTON, WV • 25302
PHONE: 304-343-7121 • FAX: 304-343-3323

DRS. MOORE & MOORE DENTAL ASSOCIATES

Please answer the following questions to help us better assist you with your dental needs.

- ***Have you had a cleaning in the past 6 months?___ If so, when?_____***
- ***Have you had a complete series of xrays or panoramic film taken in the past 3 years?___ If so, when?_____***
- ***Who was your previous dentist?_____***
- ***If you have existing bridges, crowns or dentures, please list when they were completed for future insurance references._____***

_____

- ***Is there anything about your smile that bothers you, or that you would change if you could?***

_____

_____

- ***If there was an affordable method of whitening your teeth; would you be interested?*** Yes! I am interested!_____ No, Not at this time._____
- ***Do you experience frequent pain or discomfort in your jaw or have frequent headaches?*** Yes!_____ No_____
- ***Do any of your teeth hurt at this time?*** Yes _____ No _____

If so, where? Upper Right____ Upper Left _____Lower Right _____Lower Left_____

- ***Are there any other dental concerns that you would like to discuss with the dentist?*** _____

_____

- **How did you hear about us?**_____

Thank you!

RECORDS RELEASE REQUEST

Date_____

To _____
(DOCTOR)

Address _____

City_____ State_____ Zip_____

I authorize the release of dental records and medical records relevant to dental treatment, or copies of such, and request that they be transferred to:

DRS. MOORE & MOORE DENTAL ASSOCIATES
420 Virginia St. W. — Charleston, WV 25302
Telephone: (304) 343-7121

_____ _____
Print name of patient Signature (patient, parent or guardian)