BILL GATES DDS MS Patient Registration

Patient Information

Todays date:_____ E- Mail:_____

Last Name:_____ First Name:_____

Home Address:_____
Street

_____
City State Zip code

Home Phone:(_____)_____ work phone:(_____)_____

Cell Phone:(_____)_____

Birthdate:_____/_____/_____ Social Security number:_____-_____-_____

Emergency Contact:_____ Emergency Contact #: _____

Insurance Information

Dental Carrier:_____ Subscriber name:_____

Subscriber Id #:_____ Employer Name:_____

Secondary Insurance:_____ Subscriber name:_____

Subscriber Id #:_____ Employer Name: _____

How did you hear about our office?_____

Authorizations

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature:_____ Date:_____

I certify that I am covered by _____Insurance Company and I assign directly to Dr Gates all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co- payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature:_____ Date:_____

PAYMENT IS DUE AT TIME OF SERVICE

BILL GATES DDS MS Medical Information

Today's Date: _____ Name: _____

Physician's name: _____ Physician's Phone#: _____

Do you smoke or use tobacco? ☐ Yes ☐ No

Do you have a history of or are you currently diagnosed with (mark all that apply):

☐ Abnormal Bleeding	☐ Glaucoma	☐ Stroke
☐ Alcohol Abuse	☐ Hay Fever	☐ Thyroid Problems
☐ Allergies	☐ Heart Attack	☐ Tuberculosis
☐ Anemia	☐ Heart Surgery	☐ Ulcers
☐ Angina	☐ Hemophilia	☐ Venereal Disease
☐ Arthritis	☐ Hepatitis A	☐ Yellow Jaundice
☐ Artificial Joints	☐ Hepatitis B	☐ Osteoporosis
☐ Artificial Heart Valve	☐ High Blood Pressure	
☐ Asthma	☐ HIV/AIDS	**Allergies to Medications:**
☐ Blood Transfusion	☐ Kidney Disease	☐ Aspirin
☐ Cancer - Chemotherapy	☐ Liver Disease	☐ Codeine
☐ Colitis	☐ Low Blood Pressure	☐ Dental Anesthetics
☐ Congenital Heart Defect	☐ Mitral Valve Prolapse	☐ Erythromycin
☐ Cosmetic Surgery	☐ Pacemaker	☐ Jewelry
☐ Diabetes	☐ Pneumocystitis	☐ Latex
☐ Difficulty Breathing	☐ Psychiatric Condition	☐ Metals
☐ Drug Abuse	☐ Radiation Therapy	☐ Penicillin
☐ Emphysema	☐ Rheumatic Fever	☐ Tetracycline
☐ Epilepsy	☐ Seizure	☐ Sulfa
☐ Fainting Spells	☐ Shingles	☐ Other:
☐ Fever Blisters	☐ Sickle Cell Disease	
☐ Frequent Headaches	☐ Sinus Problems	

*Please list your current medications: _____

_____

*Have you ever taken bisphosphonate medications such as Fosamax, Boniva, or Actonel? ☐No ☐Yes

*List any other medical condition not named above. _____

_____

***Female:**	Are you taking Birth Control Pills?	☐ No	☐ Yes
	Are you pregnant?	☐ No	☐ Yes # weeks____

Signature:_____ Date: _____

Today's Date: _____ Name: _____

What is your primary reason for visiting this office?_____

_____

When was your last visit to a dentist? _____

What was the reason for the last visit?_____

How do you characterize your philosophy regarding your teeth:
☐ I value preventive care
☐ I want to maintain function (chewing)
☐ I want to improve my smile
☐ I want to treat only painful teeth

Do you have:
☐ Missing teeth ☐ Cavities ☐ Painful teeth ☐ Gum Disease
☐ Painful Jaw Joints ☐ Discolored teeth

Do you use:
☐ an electric toothbrush ☐ a manual toothbrush
Do you have:
☐ a bite guard/occlusal guard ☐ bleaching trays ☐ orthodontic retainer

Have you been told that you:
☐ snore ☐ periodically stop breathing while sleeping ☐ have sleep apnea

Do you:
☐ feel excessively tired during the day ☐ fall asleep easily during the day

Dear Dental Patient:

We thank you for trusting our practice with your dental health needs. So that our practice will continue to run smoothly and we maintain a healthy patient/doctor relationship, the following policies have been implemented and we ask for your compliance.

Please be on time for your appointments. We will in turn continue to do everything in our power to respect your time and to keep you from waiting. If a patient is late for their appointment, it makes it impossible for us to stay on schedule, inconveniencing those with appointment times to follow.

If you must change a scheduled appointment time, please give us at least 48 hours notice. This is a necessity for us and a courtesy to other patients who are waiting to have their dental treatment needs met. With enough notice we may be able to provide other patients with the opportunity to make an appointment to receive care. When appointments are not kept we lose the opportunity to render a much-needed service to another patient. We reserve the right to charge a fee of $50.00 for missed appointments.

If you have dental insurance, please understand that insurance is an agreement between you and your insurance company, not an agreement or contract between the dental provider and the insurance company. Most insurance company's fee schedules are different from actual fee schedules in a dental office. As a result, there is frequently a remaining balance due after your insurance company provides your benefit. We will estimate, to the best of our ability, this difference and ask for this payment at the time services are rendered. Any remaining balance after the insurance company has paid your benefit will be your responsibility. If your insurance company fails to release your benefit within 45 days of the treatment rendered, all balances will be due from you or the guarantor responsible for your account. If insurance benefits are paid directly to the policyholder, payment is due in full at the time of service.

We can assist you in obtaining financing for some dental procedures through CareCredit & CitiHealth. If you have any interest in these financing options, please ask.

Should you desire to have a copy of any of your dental record, written consent is required for release of dental x-rays and records. Records can take up to 10 business days to duplicate.

We appreciate the opportunity to take care of all your dental needs and strive to exceed your expectations. If you have any questions or concerns about your care, please call the office number.

By signing this form, I acknowledge and accept the policies above.

X_____ Date: _____
Signature of patient/ parent/guardian

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for your privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients consent for uses of disclosure of health information about the patient to carry out treatment, payment or health care operations.

As our patient, we want you to know that we respect the privacy of your personal dental records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect that privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment, or health care operations in order to provide health care that is in your best interest.

You may have indirect treatment relationships with entities such as laboratories that only interact with doctors and not patients. These entities are most often not required to obtain patient consent. In order to provide you with proper care however, it may be necessary to disclose personal health information to these entities.

We also want you to know that we support your full access to your personal dental records. Duplicates of your records can be made at your request for a nominal duplicating fee.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under the law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent with this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any questions to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

PRINT NAME:_____SIGNATURE:_____DATE:_____

Compliance Assurance Notification For Our Patients

The misuse of PHI or Personal Health Information has been identified as a national problem causing patients inconvience, aggravation, and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with the government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule " We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the government rules, laws, and regulations. We want to ensure that our practice never contributes in any way to the growing problems of improper disclosure of PHI.

We do listen listen to our employees and our patients if they feel that an event in any way compromises our policy integrity. We welcome your input regarding any service concern so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.

Bill Gates, DDS, MS

Informed Consent:
Restorative Procedures and Use of Anesthesia

Treatment
Restorative procedures include tooth colored fillings, silver (amalgam) fillings, crowns and bridges.
Fillings are placed to restore damaged teeth and/or to enhance their appearance. The tooth is first modified or prepared by the use of a drill and an accompanying water spray. The tooth is then filled with the selected filling material.
Crowns and Bridges are placed to strengthen teeth weakened by tooth decay or root canal therapy and to replace missing teeth. This treatment involves modifying the teeth with the drill and accompanying water spray. A temporary crown or bridge is made to fit over the tooth/teeth while the final crown or bridge is being made. An impression of the modified tooth/teeth is necessary for fabrication of the new crown/bridge. Cement is used to fix the crown/bridge on to the modified tooth/teeth.
Local anesthesia is delivered from a syringe and needle assembly. Types of anesthesia commonly used include lidocaine with epinephrine, articaine with epinephrine and mepivacaine without epinephrine.

Benefits
The proposed treatment is intended to restore or improve the appearance and strength of your teeth as well as the way your teeth fit together.

Alternatives
Depending upon your needs, alternative treatments include extracting damaged teeth or correcting your bite with orthodontic treatment instead of placing crowns and bridges. Bleaching can be an alternative to cosmetic restorative treatment.

Common Risks
Reactions to anesthesia: an *allergic reaction* to local anesthesia is rare. If you do have an allergic reaction, first aid will be rendered immediately at our office. Continued medical attention at a hospital may be required. A *normal reaction* to the anesthetic if injected into a blood vessel can cause transient heart palpitations along with fainting. Localized swelling and bruising can also occur. *Altered nerve function* is a rare but significant risk in the administration of a local anesthetic. If the needle penetrates the nerve, there can be a partial or complete loss of nerve function. Both sensation and motor control can be altered after the local anesthetic wears off. The nerve damage usually resolves over a period of weeks to months. Permanent damage is a rare but possible occurrence.

Irritation to nerve tissue: preparation of a tooth for a filling or a crown may irritate the nerve tissue (pulp) inside the tooth, leaving your tooth feeling sensitive to temperature and/or pressure. This sensitivity is most commonly a transient side effect of treatment resolving in the weeks and sometimes months after treatment. Taking ibuprofen (Advil) or acetaminophen (Tylenol) can help to resolve this situation. In some cases, despite our best

care, teeth which have been filled or crowned may require root canal therapy following treatment.

Stiff or sore jaw joint: holding your mouth open during treatment may temporarily leave your jaw feeling stiff and sore making it difficult to open your mouth wide for several days after treatment. Taking ibuprofen or acetaminophen and applying moist heat to the affected area for a few days improves most symptoms.

Consequences of not performing treatment
If you do not have the recommended restorative treatment, existing problems caused by the shape or position of your teeth could result in further discomfort and possible damage to your jaw joints. For teeth that have received root canal treatment, failure to place a crown could lead to pain, infection and possibly the premature loss of the tooth. Decayed, cracked or broken teeth or teeth with inadequate restorations could continue to deteriorate, causing pain, further decay, infection, deterioration of the bone surrounding the tooth and eventually tooth loss.

Consent
Every reasonable effort will be made to ensure that your condition is treated properly. Perfect results cannot be guaranteed and risks to treatment can lead to further dental and/or medical treatment. By signing below, you acknowledge that you have received adequate information about the proposed treatment, that you understand the information and that all of your questions have been answered.

Yes, I understand the risks of restorative treatment and give my consent to treatment as recommended.

_____
Patient Signature/Date

No, I do not consent to receive restorative treatment.

_____
Patient Signature/Date