Welcome to Banner Associates D.D.S.

PATIENT REGISTRATION FORM

Please complete all required information to help us serve you better, thank you.

PATIENT/ BILLING INFORMATION

Full Name _____ Nickname _____

Birthdate _____ Driver's Lic#_____ Social Security# _____

Address _____ City, State, Zip _____

Home Phone# _____Cell Phone#_____

Email Address _____

Emergency Contact's Name & Phone# _____

Previous Dentist's Name & Phone# _____

How did you hear about us?_____

DENTAL INSURANCE INFORMATION

Primary Subscriber's Name _____ Birthdate _____

Insurance Id#_____ or Social Security# _____

Insurance Co. & Phone# _____Group# _____

Employer & Phone# _____

2nd Subscriber's Name _____ Birthdate _____

Insurance Id#_____ or Social Security# _____

Insurance Co. & Phone# _____Group# _____

Employer & Phone# _____

ADDITONAL Billing Information:

Full Name _____

Birthdate _____ Driver's Lic#_____ Social Security# _____

Address_____ City, State ,Zip _____

Email Address _____

Home Phone# _____Cell Phone#_____

Employer & Phone# _____

Consent/ Authorization/Acknowledgement

I authorize Banner Associates, D.D.S. referred to as "practice" hereafter, to take necessary radiographs, study models, photos and other diagnostic aids as needed to make a thorough diagnosis.
I authorize this practice to perform all recommended treatment and agree upon treatment. I also authorize the use of anesthetic sedatives and other medication (as needed) and I am fully aware that using anesthetic agents involves certain risks. I authorize this practice to release to staff, hospitals, health care service plans, insurance companies, self-insurers or their representatives, any and all information, records and radiographs about my medical history, services rendered and treatment necessary.
I authorize this practice to submit claims for payment for services rendered or pre-authorizations necessary to my insurance company, on my behalf and in my name listed as "signature on file" and assign to this practice the insurance benefits providing assignment is accepted. I understand that I am responsible for payment regardless of the coverage provided. I understand I am responsible for the deductible, co-payment and excess over maximum the day of service. I have received, required by law, a copy of "The Facts about Fillings" pamphlet dated 05/2004 from Banner Associates, D.D.S.

Health Insurance Portability and Accountability Act 1996:
***HIPAA**: Acknowledgment of Receipt of Notice of Privacy Practices: (You may refuse to sign this Acknowledgment)*
***HIPAA**: Consent for Use and Disclosure of Health Information:*
Notice of Privacy Practices: You have the right to read this practice's Notice of Privacy Practices before you decide to sign this Consent. Our Notice of Privacy Practices provides a description of our treatment payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information and of other important matters about your protected health information, a copy of our Notice accompanies this Consent. Please read this Notice prior to signing this Consent. This practice reserves the right to change the privacy practices as described in our Notice of Privacy Practices. If changes are made, a revised Notice of Practices containing the modifications will be issued. These changes may apply to any of your protected health information that we maintain on file. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice at any time by contacting our office at (408)842-0226. Address: Banner Associates, D.D.S. 7880 Wren Ave. Ste. A-115 Gilroy, CA 95020.
You have the right to revoke this Consent for use and Disclosure of Health Information at any time by giving us written notice of your revocation submitted to our office. This revoke will not affect previous consent. We reserve the right to refuse further treatment on your behalf or that of your dependents if this Consent is revoked.

Financial Agreement

In the effort hold costs down, payment is due when services are rendered. We accept all major credit cards for your convenience. As a courtesy to our patients who have dental insurance coverage, we will be happy to file your claim. Your deductible and co-payment are due the day of service. We will estimate these amounts for you using the information provided by your plan. Any amount exceeding your annual maximum is due when your service is rendered. In the event your insurance claim is not processed in a timely manner, we will file the claim a second time. However, further delays caused by the insurance company will require you to make full payment to our office. To expedite processing, you will need to contact the insurance company.
*We do our best to verify your health plan or insurance coverage and limitations, however this verification is only valid until the patient gives written notification to us on the proper patient registration form. Therefore, we require if any changes occur that we are to be notified prior to beginning all dental services.

Cancellation & Failed Appointment Policy

There will be a $50.00 minimum charge per hour for appointments not cancelled with at least 24 hours advance notice or for all failed appointments.

Signature below indicates the following:

I have read this entire document and fully understand the contents of this Consent/Authorization/Acknowledgment/Financial Agreement/Cancellation Policy. The information I have provided is true and accurate. I have been provided with the opportunity to ask questions and obtain further clarification.

X_____ X_____
Signature: Adult Patient /Guardian / Representative Date

Confidential Patient Health History Form

Patient's Name: _____ Birthdate: _____

I. General Information

1. Yes / No Is your general health good? _____
2. Yes / No Has there been a change in your health within the last year?

   _____
3. Yes / No Have you gone to the hospital/emergency room or had a serious illness in the last 3years?

   _____
4. Yes / No Are you being treated by a Physician now? If yes, explain below.

   _____
5. **Yes / No Have you had any problems with prior dental treatment?**

   _____
6. Yes / No Are you in pain now? _____

II. Are you currently experiencing any of the following?

Yes / No	Blood in stools	Yes / No	Vomiting	Yes / No	Fainting spells
Yes / No	Frequent Urination	Yes / No	Fever	Yes / No	Bruise easily
Yes / No	Night sweats	Yes / No	Blood in urine	Yes / No	Excessive thirst
Yes / No	Difficulty swallowing	Yes / No	Persistent Cough	Yes / No	Swollen ankles
Yes / No	Coughing up blood	Yes / No	Dizziness	Yes / No	Joint pain or stiffness
Yes / No	Bleeding problems	Yes / No	Blurred Vision	Yes / No	Shortness of breath
Yes / No	Sinus problems	Yes / No	Recent significant weight loss		

III. Have you had, or do you have any of the following?

Yes / No	Ringing in ears	Yes / No	Bruise easily	Yes / No	Headaches
Yes / No	Chest pain (angina)	Yes / No	Jaundice	Yes / No	Dry mouth
Yes / No	Heart Disease	Yes / No	Cosmetic Surgery	Yes / No	Eating disorders
Yes / No	Family history of heart disease	Yes / No	Surgeries	Yes / No	Osteoporosis
Yes / No	Heart Attack	Yes / No	Hospitalization	Yes / No	Thyroid disease
Yes / No	Artificial Joint	Yes / No	Diabetes	Yes / No	Asthma
Yes / No	Stomach problems or ulcers	Yes / No	Family history of diabetes	Yes / No	Hepatitis
Yes / No	Heart Defects	Yes / No	Tumors or cancer	Yes / No	Tuberculosis
Yes / No	Heart Murmurs	Yes / No	Chemotherapy	Yes / No	Herpes
Yes / No	Rheumatic Fever	Yes / No	Radiation	Yes / No	Canker or cold sores
Yes / No	Skin Disease	Yes / No	Arthritis, rheumatism	Yes/ No	Anemia
Yes / No	Hardening of arteries	Yes / No	Pacemaker	Yes / No	Liver disease
Yes / No	High blood pressure	Yes / No	Kidney or bladder disease	Yes / No	Eye disease
Yes / No	Seizures	Yes / No	Stroke	Yes / No	Transplants

Yes / No Artificial heart valve Yes / No Emphysema/other lung disease

Yes / No Sexual transmitted disease

*Any information will not be released unless specifically authorized by patient.

Yes / No **AIDS or HIV** Yes / No **Anxiety** Yes / No **Depression** Yes / No **Treatment for Emotional Condition** Yes / No **History of Drug Abuse**

IV. Are you allergic to or have you had a reaction to any of the following?

Yes / No	Aspirin	Yes / No	Valium	Yes / No	Tetracycline
Yes / No	Darvon	Yes / No	Demerol	Yes / No	Vicodin
Yes / No	Codeine	Yes / No	Penicillin	Yes / No	Chlorhexidine
Yes / No	Latex	Yes / No	Food	Yes / No	Nitrous Oxide
Yes / No	Local Anesthetic	Yes / No	Erythromycin	Yes / No	Metal
Yes / No	General Anesthetic	Yes / No	Azithromycin	Yes / No	Sulfa

Others: _____

V. Are you taking / have you taken any of the following in the last 3 months?

Yes / No	Recreational Drugs	Yes / No	Tobacco in any form	Yes / No	Antibiotics
Yes / No	Over-the-counter medicines/Aspirins	Yes / No	Vaping in any form	Yes / No	Supplements

Please list all medications you are currently taking. _____

_____

_____

VI. All Patients

Yes / No Do you have / have you had any other diseases or medical problems NOT listed on this form?

_____

Yes / No **Have you ever been pre-medicated for dental treatment? If yes, explain below.**

_____

Yes / No Have you ever taken Fen-Phen? If Yes, when? _____

Yes / No Have you ever taken *Bisphosphonate (Fosamax)*If yes, when? _____

This section is for women only.

Yes / No Are you or could you be pregnant? If YES, what month? _____

Yes / No Are you currently nursing? _____

Yes / No Are you currently taking birth control pills? _____

Medical Physician's Name & Phone#: _____

I authorize the dentist to contact my physician regarding dental treatment.

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically compromised situation, medical consultation may be needed prior to commencement of dental treatment. I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or admissions that I may have made in the completion of this form.

Signature: _____ Date: _____

Adult patient /Guardian/Personal Representative