Premier Dental
Daniel J. Beninato, D.D.S. & Associates
Family, Cosmetic, & Sedation Dentistry

PATIENT REGISTRATION

NP PW & CONSENTS

First Name:______________________ **Last Name:**________________**Middle Initial:**_____

Preferred Name:__________________ **Patient Is:** O Responsible Party O Policy Holder

Patient Information

Address:______________________________City:____________State:_______Zip Code:_________

Home Phone:__________________ Work Phone:____________Ext:_________ Cell:________________

Sex: O Male O Female Marital Status: O Married O Single O Divorced O Separated O Widowed

Birth Date:__________________

If patient is the Responsible Party: Driver's License #:________________ Soc. Sec. #:________________

Referred By: O T.V O Radio O Insurance O Internet O Flyer O Location O Patient:__________ O Other:__________

Your Employer:____________________________________ Your Occupation:________________

Employment Status: O Full Time O Part Time O Retired Student Status: O Full Time O Part Time O N/A

Emergency Contact Name & Phone #:____

Preferred Pharmacy & Location:____

Primary Care Physician Name & Phone #:_____________________________________

Responsible Party – Account/Payment
(If someone other than patient)

Relationship to patient: O Spouse O Mother O Father O Guardian O Other:____________________

Name:___________________________ Address:_________________________________

City:___________________________ State:______________ Zip Code:____________

Home Phone:__________________ Work Phone:____________Ext:_________ Cell:________________

Birth Date:__________________ Soc. Sec. #:________________ Drivers License #:______________

For children 18 years and younger – Parent Information
(If any other than Responsible Party)

O Mother O Stepmother O Guardian Name:_____________________________________

Home Phone:__________________ Work Phone:____________Ext:_________ Cell:________________

O Father O Stepfather O Guardian Name:_____________________________________

Home Phone:__________________ Work Phone:____________Ext:_________ Cell:________________

If a parent/guardian's address is different than Responsible Party, notify the Front Desk.

Primary Insurance Information

Relationship to Insured: O Self O Spouse O Child O Other

Employer:_______________________________

Ins. Company:___________________________

Ins. Address:___________________________

If the information requested below is the same as the Responsible Party entered above, mark the circle below and leave blank

O Name of Insured:______________________

O Insured Soc. Sec. #_____________________

O Insured Birth Date:_____________________

Secondary Insurance Information

Relationship to Insured: O Self O Spouse O Child O Other

Employer:_______________________________

Ins. Company:___________________________

Ins. Address:___________________________

If the information requested below is the same as the Responsible Party entered above, mark the circle below and leave blank

O Name of Insured:______________________

O Insured Soc. Sec. #_____________________

O Insured Birth Date:_____________________

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PATIENT REGISTRATION *FAMILY ADDENDUM*

List each additional child in the family below:

Patient's First Name, Last Name & Middle Initial	Preferred Name	Gender	Birth Date

PLEASE COMPLETE A MEDICAL HISTORY FORM FOR EACH CHILD LISTED ABOVE

If a parent/guardian's address is different than the Responsible Party listed, please complete the corresponding section below:

O Mother **O** Stepmother **O** Guardian	**O** Father **O** Stepfather **O** Guardian
Address: ________________________________	Address: ________________________________
City: ________________________________	City: ________________________________
State: ________________________________	State: ________________________________
Zip Code: ________________________________	Zip Code: ________________________________

If there is any additional information that we should have regarding the family's home situation, such as custody arrangements, foster care, etc., please provide in the section below:

____

____

____

Medical History

Patient Name:____ **Date of Birth**:______________________

Are you under a physician's care now? **O** Yes **O** No If yes:_______________________________________

Have you ever been hospitalized or had a major operation? O Yes O No If yes:______________________________

Have you ever had a serious head or neck injury? **O** Yes **O** No If yes:_________________________________

Are you taking any medications, pills, or drugs? **O** Yes **O** No If yes:_________________________________

Do you take or have you taken Phen-fen or Redux? **O** Yes **O** No If yes:_________________________________

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? **O** Yes **O** No If yes:_________________________________

Are you on a special diet? **O** Yes **O** No **Do you use tobacco?** **O** Yes **O** No

Women: Are you... **O** Pregnant/Trying to get pregnant? **O** Nursing? **O** Taking Oral Contraceptives?

Are you allergic to any of the following?

O Aspirin O Penicillin **O** Codeine **O** Acrylic **O** Metal **O** Latex **O** Sulfa Drugs

O Local Anesthetics **O** Other? If yes:_________________________________

O None of the above

Do you use controlled substances? O Yes O No If yes:_________________________________

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

AIDS/HIV Positive	Y	N	Cortisone Medicine	Y	N	Hemophilia	Y	N	Radiation Treatments	Y	N
Alzheimer's Disease	Y	N	Diabetes	Y	N	Hepatitis A	Y	N	Recent Weight Loss	Y	N
Anaphylaxis	Y	N	Drug Addiction	Y	N	Hepatitis B or C	Y	N	Renal Dialysis	Y	N
Anemia	Y	N	Easily Winded	Y	N	Herpes	Y	N	Rheumatic Fever	Y	N
Angina	Y	N	Emphysema	Y	N	High Blood Pressure	Y	N	Rheumatism	Y	N
Arthritis/Gout	Y	N	Epilepsy or Seizures	Y	N	High Cholesterol	Y	N	Scarlet Fever	Y	N
Artificial Heart Valve	Y	N	Excessive Bleeding	Y	N	Hives or Rash	Y	N	Shingles	Y	N
Artificial Joint	Y	N	Excessive Thirst	Y	N	Hypoglycemia	Y	N	Sickle Cell Disease	Y	N
Asthma	Y	N	Fainting Spells/Dizziness	Y	N	Irregular Heart Beat	Y	N	Sinus Trouble	Y	N
Blood Disease	Y	N	Frequent Cough	Y	N	Kidney Problems	Y	N	Spina Bifida	Y	N
Blood Transfusion	Y	N	Frequent Diarrhea	Y	N	Leukemia	Y	N	Stomach/Intestinal Disease	Y	N
Breathing Problems	Y	N	Frequent Headaches	Y	N	Liver Disease	Y	N	Stroke	Y	N
Bruise Easily	Y	N	Genital Herpes	Y	N	Low Blood Pressure	Y	N	Swelling of Limbs	Y	N
Cancer	Y	N	Glaucoma	Y	N	Lung Disease	Y	N	Thyroid Disease	Y	N
Chemotherapy	Y	N	Hay Fever	Y	N	Mitral Valve Prolapse	Y	N	Tonsillitis	Y	N
Chest Pains	Y	N	Heart Attack/Failure	Y	N	Osteoporosis	Y	N	Tuberculosis	Y	N
Cold Sores/Fever Blisters	Y	N	Heart Murmur	Y	N	Pain in Jaw Joints	Y	N	Tumors or Growths	Y	N
Congenital Heart Disorder	Y	N	Heart Pacemaker	Y	N	Parathyroid Disease	Y	N	Ulcers	Y	N
Convulsions	Y	N	Heart Trouble/Disease	Y	N	Psychiatric Care	Y	N	Venerial Disease	Y	N
									Yellow Jaundice	Y	N

Have you ever had any serious illness not listed? **O** Yes **O** No If yes:_________________________________

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Please write in any other pertinent information that has not been covered.

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Authorization: I hereby authorize the Doctor and/or team member of this dental office to administer such medications and to perform such diagnostic and therapeutic procedures as may be necessary for proper dental care as agreed upon through consultation with me. The information which appears, on these medical and dental histories is correct to the best of my knowledge. I also authorize the doctor and/ or team member to contact my healthcare giver(s) concerning my treatment if necessary.

____ _______________________

Patient/Parent/Guardian Signature **Date**

THE FINANCIAL & INSURANCE POLICIES OF PREMIER DENTAL

Daniel J. Beninato, D.D.S. & Associates
Family, Cosmetic, & Sedation Dentistry

I understand that services rendered to me by Premier Dental are my financial responsibility and that the provider will bill my insurance company as a **courtesy.** I authorize my insurance company to pay my benefits directly to Premier Dental and I understand that I will be fully responsible for an outstanding balance on my account. We estimate your portion based on the most up-to-date information we have, but it is ***only an estimate.*** It is the responsibility of the patient to be aware of their individual policy limitations and requirements. All payments are due the day of the appointment. For appointments 60 minutes or longer we will collect the co-pay one week prior to reserve your scheduled time **unless previous arrangements have been made**. I also understand that missed or broken appointments without 2 business days notice increases the cost of dental treatment and that there may be a charge for missed or broken appointments.

I authorize the provider to release any information necessary to adjudicate the claim and understand that there may be associated cost for providing information beyond what is necessary for the adjudication of a clean claim. I authorize the provider to initiate a complaint or file an appeal to the insurance commissioner or any payer authority for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials.

I also understand that should my insurance company send payment to me, I will forward the payment to Premier Dental within 48 hours. I agree that if I fail to send the payment to Premier Dental and they are forced to proceed with the collections process, I will be responsible for any cost incurred by the office to retrieve their monies. In the event I receive any check, draft, or other payment subject to this agreement, I will immediately deliver said check, draft, or payment to Premier Dental. Any violations of this agreement will terminate charge privileges and bring any balance owed by the responsible party to Premier Dental immediately due and payable.

____ ___________________________________

Patient/Parent/Guardian Signature **Date**

APPOINTMENT REMINDERS

I prefer the following appointment reminders (check all that apply):

O Text only **O** Email only **O** Text & Email *If none are selected, you will receive reminders by phone.*

Email:____

Reminder texts, emails and phone calls for children under 18 yrs old will go to the phone/email on file for the Responsible Party.

PHOTOGRAPHY RELEASE

I, __________________________, hereby consent and authorize Dr. Beninato and his team at Premier Dental to take photographs, slides, and/or videos of my face, jaws and teeth.

I understand that the photographs, slides, and/or videos will be used as a record of my care, and may be used with or without my given name or with a fictitious name for educational purposes in lectures, demonstrations, advertising, professional publications (dental magazines and journals) and any other lawful purpose.

I release and forever discharge Dr. Beninato or any member of Premier Dental from any claim, demands, or liability on account of such use or for the quality of the reproduction of the image.

____ ___________________________

Patient/Parent/Guardian Signature **Date**

____ ___________________________

Witness **Date**

NOTICE OF PRIVACY PRACTICES

Daniel J. Beninato, D.D.S. & Associates
Family, Cosmetic, & Sedation Dentistry
17110 Lakeside Hills Plaza Omaha, NE 68130
Phone: (402) 330-6757 Email: info@premiersmile.com

I give this practice my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.
I have been informed that I may review the practice's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.
I understand that this practice has the right to change their privacy practices and that I may obtain any revised notices at the practice.
I understand that I have the right to request a restriction of how my processed health information is used. However, I also understand that the practice is not required to agree to the request. If the practice agrees to my requested restriction, they must follow the restrictions.
I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

I,____, hereby give authorization for Premier Dental to release;

O **Treatment Records** O **Account Records** O **Appointment Information** (check all that apply)

to the following person(s);____

You have the right to revoke this consent to release information at any time by submitting your request in writing to Premier Dental. Requests via mail can be sent to: Premier Dental Attn: Front Desk 17110 Lakeside Hills Plaza Omaha, NE 68130 Email: info@premiersmile.com Fax: (402)330-6713

CONTACT PREFERENCES

Please contact the following person for anything related to (check all that apply):

Treatment/Appointments:	**O** Patient	**O** Spouse	**O** Mother	**O** Father	**O** Guardian
Account/Insurance:	**O** Patient	**O** Spouse	**O** Mother	**O** Father	**O** Guardian

HIPPA CONSENT TO LEAVE MESSAGE

- I wish to be called at (*check all that apply*) **O** home **O** work **O** cell regarding my care and follow up.
- **O** I do **O** I do not give permission to leave relevant medical information on my answering machine or voice mail.
- **O** I do **O** I do not want relevant medical information shared with the person who may answer the telephone. If not, the name(s) of the individual(s) with whom you may leave pertinent information are:

____ ____

____ ____

____ ________________________

Patient/Parent/Guardian Signature **Date**