GRIECO

Biological, Cosmetic & Holistic Dentistry

DENTAL REGISTRATON

Patient Name ______________________________ Today's Date ____________
Address ____
City ___________________________ State _____________ Zip ______________
Home Phone ___________________ Cell Phone __________________________
Date of Birth ___________________
Preference to be contacted Home____ Cell____ Work____
Martial Status Single____ Married____ Widow____ Other_________________
Email ____
Employer ____
Work Phone ____________________ Occupation___________________________
Emergency Contact Name ____
Emergency Contact Phone _______________________
Relationship to Patient ____
Person Responsible for Account / Patient Self____ Parent____ Other____
If Other, Name and Phone ____

Insurance:

Patients with dental insurance, please provide all information to the front desk. (Note: We are **non-participating with ALL dental insurance plans**, but will utilize your insurance to get you the best reimbursement as possible if you are allowed to go out of network. **All patients are responsible to pay fees in full at time of service regardless of insurance or not. Thank you.**

Medical History:

(Please check and answer all questions so that we can provide the best dental care without no interrelationship with health problems or medications you may be taking at this time.)

Congenital Heart Problems--	Y / N	Heart Defect/Murmur----	Y / N
Rheumatic Heart Disease----	Y / N	Rheumatic Fever---------	Y / N
Scarlet Fever--------------------	Y / N	Organ Transplant--------	Y / N
Mitral Valve Prolapse---------	Y / N	Joint Replacement-------	Y / N
Asthma---------------------------	Y / N	Anemia---------------------	Y / N
Diabetes-------------------------	Y / N	Hepatitis---------------------	Y / N
Jaundice/Liver Disease-------	Y / N	Cold Sore/Fever Blister--	Y / N
Epilepsy/Seizures-------------	Y / N	Aids or HIV-----------------	Y / N
Sexual Transmitted Disease-	Y / N	Mental Health Care-------	Y / N
Chemical Dependency--------	Y / N	Eating Disorders-----------	Y / N
Chemotherapy------------------	Y / N	Cancer----------------------	Y / N
Leukemia------------------------	Y / N	Dementia/Alzheimer-------	Y / N

1. Are there any other health conditions, which are not listed above, that we should be aware of? Y / N Please list ______________________
   ____
2. Have you ever been instructed to premedicate prior to dental appointments? Y / N
3. If yes, what antibiotics were you prescribed? ______________________
4. Are you currently under medical treatment? Y / N
5. Are you currently taking any medication? Y / N
   Please list ____
   ____
   ____
6. Have you ever had any serious illness or operations? Y / N
   Please List: ____
7. Do you use tobacco products? Y / N Please List: _______________
8. Do you wear contacts? Y / N
9. Are you pregnant or think you may be? Y / N
   Nursing? Y / N
   Taking birth control? Y / N

Allergies:

Aspirin---------------------------- Y / N
Metals---------------------------- Y / N
Please list: ___________________
Antibiotics----------------------- Y / N
Please list: _______________
Sleeping Pills----------------- Y / N
Others not listed-------------- Y / N
Please list: _____________________

Iodine------------------------- Y / N
Latex/Rubber--------------- Y / N
Local Anesthetics---------- Y / N
Sulfa Drugs------------------ Y / N
Sedatives-------------------- Y / N
Barbiturates----------------- Y / N

Authorization and Release

*(This section **must be** read and signed **before** treatment can be performed.)*

I certify that I have read and understand the above information. All questions have been answered to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including diagnosis and the records of any treatment or examination rendered to me or my child during the period o such dental care to third party payors and/or health practitioners. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I agree to allow Dr Derek P Grieco, DMD and his staff to treat my or my dependents dental needs.

Signature of Patient or Parent/Guardian of Minor:

X____ Date____________

NOTICE OF PRIVACY

HIPAA is the Health Insurance Portability and Accountability Act. It was put into place to protect patient privacy and also ensures privacy of all accumulated health information that belongs to the patient. It was signed into law in 1996 under the United States Dept of Health and Human Services.

Our Office Privacy Practices

All information that is obtained from you by Dr Derek Grieco is protected and kept confidential under HIPAA. Every reasonable measure to prevent unauthorized disclosure of your protected health information is practiced.

Uses and Disclosures

- Your protected health information is accessed and used for healthcare related purpose only.
- Your protected health information is never sold, rented, transferred, exchanged, and/or used for non-healthcare related purposes including marketing activities without your written authorization.
- Your protected health information can be disclosed without your written authorization in certain limited circumstance such as: medical emergencies, in situations required by law, individuals involved in your care, when requested by public health agency, and when requested by law enforcement agency.
- For any purpose other than treatment, obtaining payment, healthcare operations, or certain circumstances, we will ask for your written authorization before using or disclosing your protected health information. If you choose to sign an authorization to disclose protected health information, you can revoke that authorization in writing at any time.
- Dr Derek Grieco may use your information for research or teaching purposes, but your face photo or name is never used.

Patient Rights

- You have the right to request in writing to inspect and/or receive a copy of your health information.
- You have the right to request an alternate means or location to receive communications regarding your health information.
- You have the right to request in writing to amend, correct, or delete any recorded health information within our possession.
- You have the right to request in writing to restrict some of the uses and disclosures of your health information.
- You have the right to request in writing an accounting of certain disclosures of your health information that were made by this office.

KEEP IN MIND THAT IF YOU WANT YOUR MEDICAL RECORDS FROM OUR OFFICE SENT TO ANOTHER, A RELEASE FORM WILL HAVE TO BE SIGNED.

Signature: ____ **Date:** ____________