ALAN P. FRIZ, D.D.S.
1411 N. Chestnut Street
Huntingburg, IN 47542

NEW PATIENT REGISTRATION

NAME_____
ADDRESS_____
CITY_____ ST____ ZIP_____
HOME PHONE _____
WORK PHONE _____
CELL PHONE _____
BIRTHDAY OF PATIENT_____
SOCIAL SECURITY # OF PATIENT _____
INSURANCE CO. NAME _____
PLACE OF EMPLOYMENT _____
SPOUSE'S NAME _____
PHYSICIAN'S NAME _____
PREVIOUS DENTIST _____
WHO REFERRED YOU TO OUR OFFICE?

_____

IF SOMEONE ELSE IS RESPONSIBLE FOR INSURANCE OR PAYING YOUR BILL, PLEASE COMPLETE BELOW

NAME_____
ADDRESS_____
CITY _____
STATE_____ZIP _____
HOME PHONE _____
EMPLOYED BY _____
INSURANCE CO. _____
INSURED'S BIRTHDAY__ _____
INSURED'S SOCIAL SEC #_____

Optional information
Your e-mail address:_____
Your facebook address:_____

CHECK METHOD OF PAYMENT: CASH _____ CHECK _____
CREDIT CARD _____ HOOSIER HEALTHWISE _____
INSURANCE _____

This is to certify that, I the undersigned, consent to the performing of the dental and oral surgery procedures agreed to be necessary or advisable, including the use of local or general anesthesia, as indicated. I understand that Dr. Friz's office will make every effort to quote accurate insurance coverage, but I understand I am ultimately responsible for payment of my account.

I, the undersigned, agree to pay any expenses for which the doctor may incur in collecting any balances due on past due accounts, including a reasonable attorney's fee and other costs and charges for the collection thereof. In the event that more than three appointments are missed without 48 hours notice, our office reserves the right to dismiss you as a patient. The personal information contained on this form is highly confidential. It is intended for the exclusive use of Dr. Friz's office. Any other use is a violation of federal law (HIPAA) and will be reported.

_____ _____
Patient's or Guardian's signature Date

ALAN P. FRIZ, D.D.S. **Pt's Name:**

PATIENT MEDICAL HISTORY

___YES ____NO ARE YOU UNDER ANY MEDICAL TREATMENT NOW?
___YES ____NO HAVE YOU HAD ANY MAJOR OPERATION?
IF YES, WHAT?_____
___YES ____NO HAVE YOU EVER HAD A SERIOUS ACCIDENT INVOLVING HEAD OR JAW?
____YES ____NO HAVE YOU HAD ANY ADVERSE REACTIONS TO ANY DRUGS?
NAME OF DRUG YOU HAD REACTION TO:
_____

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

___HEART AILMENT
___HIGH BLOOD PRESSURE
___LOW BLOOD PRESSURE
___RESPIRATORY
___DIABETES
___RHEUMATIC FEVER
___RHEUMATISM OR ARTHRISTIS
___TUMORS OR GROWTHS
___TUBERCULOSIS
___AIDS
___ BLOOD DISEASE
____LIVER DISEASE
___KIDNEY DISEASE
___STOMACH OR INTESTINAL DISEASE
___VENEREAL DISEASE
___YELLOW JAUNDICE OR HEPATITIS
___EPILEPSY

___YES ___NO ARE YOU ON A DIET?
___YES ___NO ARE YOU NOW TAKING ANY MEDICATIONS? (list current meds below)
___YES ___NO ARE YOU ALLERGIC TO ANY KNOWN MATERIALS RESULTING IN HIVES ASTHMA, OR ECZEMA?
___YES ___NO DO YOU HAVE ANY REASON TO SUSPECT YOU ARE NOT IN GOOD HEALTH?
___YES ___NO DO YOU HAVE ANY SLOW HEALING WOUNDS?
___YES ___NO ARE YOU PREGNANT?
___YES ___ NO DO YOU HAVE A HISTORY OF FAINTING?
___YES ___NO HAVE YOU EVER HAD X-RAY TREATMENTS OTHER THAN DIAGNOSTIC?
___YES ___NO HAVE YOU RECEIVED ANY DONOR ORGANS, ARTIFICIAL HEART VALVES, JOINT IMPLANTS OR PACEMAKER?

PATIENT DENTAL HISTORY

____YES ____ NO DO YOU HAVE ANY SPECIFIC DENTAL PROBLEMS?
____YES ____NO DO YOU HAVE PAIN IN OR NEAR YOUR EARS?
____YES ____NO DO YOU HAVE ANY UNHEALED INJURIES, INFLAMED AREAS IN OR AROUND YOUR MOUTH?
____YES ____NO HAVE YOU EXPERIENCED ANY GROWTH OR SORES SPOTS IN YOUR MOUTH
____YES ____ NO DOES ANY PART OF YOUR MOUTH HURT WHEN CLENCHED?
____YES ____ NO HAVE YOU EVER HAD ANY REACTIONS TO DENTAL INJECTIONS?
____YES ____ NO ANY DIFFICULT EXTRACTION IN THE PAST?
____YES ___NO HAVE YOU HAD PROLONGED BLEEDING BLEEDING AFTER AN EXTRACTION?
____YES ___NO DO YOUR GUMS BLEED?
____YES ___NO HAVE YOU EVER BEEN INSTRUCTED ON THE CORRECT METHOD OF BRUSHING YOUR TEETH?
___YES ___NO HAVE YOU EVER BEEN INSTRUCTED ON THE CARE OF YOUR GUMS?
___YES ___NO DO YOU CHEW ON ONLY ONE SIDE OF YOUR MOUTH?
___YES ___NO DO YOU HABITUALLY CLENCH YOUR TEETH?
___YES ___NO HAVE YOU RECENTLY TRAVELED ABROAD?
___YES ___NO HAVE YOU EVER USED TOBACCO PRODUCTS ?
WHEN & WHERE WERE YOUR LAST X-RAYS TAKEN?
_____

____YES ___NO ANY PART OF YOUR MOUTH SORE TO PRESSURES OR IRRITANTS?
_____

Certification: I certify that the answers given are correct to the best of my knowledge.

_____ _____
SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

_____

RECERTIFICATION: I CERTIFY THAT THERE HAVE BEEN NO CHANGES IN MY HEALTH EXECPT AS NOTED BELOW.

CURRENT MEDICATION REASON

(office use only)

DATE CHANGES SIGNATURES

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ALAN P. FRIZ, D.D.S.

HIPPA PRIVACY PRACTICES RELEASE FORM

****You May Refuse to Sign This Acknowledgement****

Patient's name (Please print)_____

I understand I may request a copy of the Notice of Privacy Practices for review.

_____ I agree to have my records shared with the following people:

Authorized Person_____

Authorized Person_____

_____ I agree to allow Dr. Friz's office to fax excuse for dental appointment to my employer

_____ If patient is a minor student, I give Dr. Friz's office my permission to fax excuse for dental appointment to my student's school

You have the right to terminate this authorization at any time by contacting our office in writing.

Our office has no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of Dr. Alan Friz's office.

_____ _____

Signature of patient or guardian Date

If you wish to refuse this authorization, please check line below and sign.

_____ I am exercising my right to refuse to sign the Notice of Privacy Practice

_____ _____

Signature of patient or guardian refusing to sign HIPPA form Date

Office Use Only

Our office attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Explain_____