PATIENT REGISTRATION

Patient Information

Patient: ____ Male ___ Female ___
First Name M.I. Last Name "Goes By"

Home Phone # __________________ Work # __________________ Cell # __________________

Email Address ______________________ Birth Date ____________ SSN# ________________

I prefer contact by email, text message or phone call? _______________________________________

Mailing Address: ____
Street Apt. # City State Zip

Employer ______________________________ Occupation ______________________________

What are some of your hobbies and interests? ____

If Patient is a Child, Father's Name __________________Mother's Name ___________________

Spouse or Person to Contact in the Event of an Emergency

Name _________________________ Relationship ______________ Phone _________________

Account Information

Is "Patient" also "Person Responsible"? Yes____ No ____ If Yes, skip this section.

Person Responsible ___________________________ Relationship to Patient _______________

Home Phone # _________________ Work # ________________ Cell # ___________________

Email Address ______________________ Birth Date ____________ SS# ________________

Mailing Address: ____
Street Apt. # City State Zip

Insurance Information

Is Patient also the Insured? Yes ___No ___ Is there Secondary Insurance? Yes ___No ___

Name of Insured ___________________________ Employer ______________________________

Birth Date _____________SSN# _____________*Insurance Company _______________________

We'll get the rest of the information about your insurance/benefit plan(s) from your insurance/benefit card(s).

I understand this office is considered "out-of-network" for all insurance plans. I agree to be responsible in full for all fees for services provided.

Responsible Person's Signature ______________________________ Date ________________

JAMES B. POLLEY, D.D.S.
Smile Artistry

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please read it carefully. The privacy of your health information is important to us.

The Purpose of this Notice:
Federal and state law requires us to maintain the privacy of your health information. We are also required to give you this Notice to help you understand what our legal duties are, how we will protect your health information, when and how we will share your health information, and your rights concerning your health information.

Uses and Disclosures With Authorization:
You may give us written authorization to use your health information or to disclose it to anyone for any purpose. You can cancel this at any time by notifying us in writing to stop any further use or disclosure. The cancelation of authorization will not affect any information that has already been shared.

Uses and Disclosures Not Requiring Your Authorization - Most Common Reasons:
Treatment: We may share your health information with another dentist, physician or other healthcare provider providing treatment to you. We may also disclose health information to a family member or friend who is involved with your care or payment if we believe it is in your best interest to do so.

Payment: We may share your healthcare information with health plans, insurers, family members and/or friends involved in your care, to obtain payment for services we provide to you.

Healthcare Operations: We may share health information about you to run our practice, including review of our treatment services, training, evaluation of the performance of our staff, quality assurance, financial and billing audits, legal matters, and business planning and development.

Uses and Disclosures Not Requiring Your Authorization - Examples of Other Reasons:

<u>For your treatment and payment</u>
- When you need emergency care
- To tell you about treatment choices
- To remind you about appointments

<u>For Public Health Reasons</u>
- To help researchers study health problems
- To help public health officials stop the spread of disease or prevent injury
- To protect you or another person if we think you are in danger

<u>Other special uses</u>
- To help police, courts and other people who enforce the law
- To obey laws about reporting abuse and neglect
- To report information to the military
- To obey court orders
- For worker's compensation
- To help government agencies review our work and investigate problems help our business partners do their work

Your Rights:

To exercise any of these rights, you must submit a written request to the Privacy Official listed at the end of this Notice.

- You may ask us to give you a paper copy of the Notice at any time.
- You can ask us to place additional restrictions on how we use or disclose your health information to carry out treatment, payment or health care operations or to your family member or friend involved in your care or the payment for your care. We may not (and are not required to) agree to your requested restrictions.
- You may ask to restrict the release of your health information to a health plan when you have paid out of pocket in full for items or services.
- You can ask to look at your health information and get a copy of it in a reasonable and mutually agreeable format. You may be charged a reasonable fee to cover the cost of providing copies of your health information. We may deny your request for access to your health information under certain circumstances.
- If you think something is missing from or wrong in your health record, you can ask us to make changes.
- You can ask us to give you a list of the times (after April 14, 2003) that we have shared your health information with someone else. This will not include the times we have shared your information for the purposes of treatment, payment or health care operations.
- You can ask us to mail health information to an address that is different from your usual address or to deliver the information to you in another way.

Our Responsibilities:

- Under the law, we must keep your health information private except in situations like the ones listed in this notice.
- We must give you this notice that explains our legal duties about privacy.
- We must follow what we have told you in this notice.
- We will only use or share the minimum amount of your health information necessary to perform our duties.

Questions and Complaints:

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy right, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the uses or disclosure of your health information, you may complain to us using the contact information listed at the end of the Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services Office. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint.

Contact Information:
Contact Officer: James B. Polley, DDS
Address: 1875 Village Center Circle, #110, Las Vegas, NV 89134
Telephone: (702) 873-0324 Fax: (702) 873-6368
Email: polleydds@gmail.com

We have the right to change this notice and the way your health information is protected at any time, provided such changed are permitted by applicable law. If this happens, we will change the Notice and make the new Notice available upon request.

JAMES B. POLLEY, D.D.S.
Smile Artistry

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of this Dental Practice's **Notice of Privacy Practices**.

____
Print Patient Name

_______________________________ _____________
Patient Signature Date

OR

_____________________________ ______________________________
Signature of Personal Representative Print Name of Personal Representative

Authority of Personal Representative to Sign for Patient (check one):

___ Parent ___ Guardian ___ Power of Attorney ___ Other: _________

Dental Office Use Only

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

___ An emergency prevented us from obtaining acknowledgement

___ A communication barrier prevented us from obtaining acknowledgement.

___ Other: ____

Staff Member Signature ___________________________ Date _________________

DENTAL HISTORY

Patient Name ______________________ Nickname ______________________ Age ________

Referred by ______________________ How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist ______________________ How long have you been a patient? ______________ Months/Years

Date of most recent dental exam ____ /____ /____ Date of most recent x-rays ___ /____ /____

Date of most recent treatment (other than a cleaning) ____ /____ /____

I routinely see my dentist every ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? ______________________

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

PERSONAL HISTORY	○ ○ ○	YES	NO
1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [___]		☐	☐
2. Have you had an unfavorable dental experience?		☐	☐
3. Have you ever had complications from past dental treatment?		☐	☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic?		☐	☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age?		☐	☐
6. Have you had any teeth removed, missing teeth that never developed, or lost teeth due to injury or facial trauma?		☐	☐

GUM AND BONE	○ ○ ○	YES	NO
7. Do your gums bleed sometimes or are they ever uncomfortable when brushing or flossing?		☐	☐
8. Have you ever had or been told you have gum loss, gum disease, or bone loss between your teeth?		☐	☐
9. Have you ever noticed an unpleasant taste, odor in your mouth, or swollen and puffy gums?		☐	☐
10. Is there anyone with a history of periodontal disease in your family?		☐	☐
11. Have you ever experienced gum recession, or can you see more of the roots of your teeth?		☐	☐
12. Have you ever had any teeth become loose on their own (without an injury), or feel them move when chewing?		☐	☐
13. Have you experienced a burning, painful sensation, or metallic taste in your mouth?		☐	☐

TOOTH STRUCTURE	○ ○ ○	YES	NO
14. Have you had any cavities within the past 3 years?		☐	☐
15. Does the amount of saliva in your mouth seem too little, not enough, or do you have difficulty swallowing or chewing any food?		☐	☐
16. Do you feel or notice any holes (i.e., pitting, craters) on the biting surface of your teeth?		☐	☐
17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?		☐	☐
18. Do you have grooves or notches on your teeth near the gum line?		☐	☐
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?		☐	☐
20. Do you frequently get food caught between any teeth?		☐	☐

BITE AND JAW JOINT	○ ○ ○	YES	NO
21. Does your jaw joint ever have pain, sounds (popping, cracking), or experience limited opening or locking?		☐	☐
22. Do you feel like you need to pull your lower jaw back, or feel that it is being pushed back when you try to bite your back teeth together?		☐	☐
23. Do you avoid or have difficulty chewing gum, raw carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?		☐	☐
24. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed?		☐	☐
25. Are your teeth becoming more crooked, crowded, or overlapped?		☐	☐
26. Are your teeth developing spaces or becoming more loose?		☐	☐
27. Do you have more than one bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together better?		☐	☐
28. Do you place your tongue between your teeth or close your teeth against your tongue?		☐	☐
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?		☐	☐
30. Do you clench or grind your teeth together in the daytime / nighttime or ever make them sore?		☐	☐
31. Do you have any problems with sleep (i.e., restlessness or teeth grinding), wake up with a headache or an awareness of your teeth?		☐	☐
32. Do you wear or have you ever worn a bite appliance?		☐	☐

SMILE CHARACTERISTICS	○ ○ ○	YES	NO
33. Is there anything about the appearance of your mouth (smile, lips, teeth, gums) that you would like to change (color, spaces, size, shape, display)?		☐	☐
34. Have you ever bleached (whitened) your teeth?		☐	☐
35. Have you felt uncomfortable or self-conscious about the appearance of your teeth?		☐	☐
36. Have you been disappointed with the appearance of previous dental work?		☐	☐

Patient's Signature ______________________ Date __________

Doctor's Signature ______________________ Date __________

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MEDICAL HISTORY

Patient Name ______________________ Nickname ____________ Age ____________

Name of Physician/and their specialty ______________________

Most recent physical examination ______________ Purpose ______________

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD:

		YES	NO
1.	hospitalization for illness or injury ______	☐	☐
2.	an allergic or bad reaction to any of the following:	☐	☐
	○ aspirin, ibuprofen, acetaminophen, codeine ______		
	○ penicillin ______		
	○ erythromycin ______		
	○ tetracycline ______		
	○ sulfa ______		
	○ local anesthetic ______		
	○ fluoride ______		
	○ chlorhexidine (CHX) ______		
	○ Iodine ______		
	○ metals (nickel, gold, silver, ______)		
	○ latex ______		
	○ nuts ______		
	○ fruit ______		
	○ milk ______		
	○ red dye ______		
	○ other ______		
3.	heart problems, or cardiac stent within the last six months ______	☐	☐
4.	history of infective endocarditis ______	☐	☐
5.	artificial heart valve, repaired heart defect (PFO) ______	☐	☐
6.	pacemaker or implantable defibrillator ______	☐	☐
7.	orthopedic or soft tissue implant (e.g., joint replacement, breast implant) ______	☐	☐
8.	heart murmur, rheumatic or scarlet fever ______	☐	☐
9.	high or low blood pressure ______	☐	☐
10.	a stroke (taking blood thinners) ______	☐	☐
11.	anemia or other blood disorder ______	☐	☐
12.	prolonged bleeding due to a slight cut (or INR > 3.5) ______	☐	☐
13.	pneumonia, emphysema, shortness of breath, sarcoidosis ______	☐	☐
14.	chronic ear infections, tuberculosis, measles, chicken pox ______	☐	☐
15.	breathing problems (e.g., asthma, nasal breathing, stuffy nose, sinus congestion)	☐	☐
16.	sleep problems (e.g., sleep apnea, snoring, insomnia, restless sleep, bedwetting) ______	☐	☐
17.	kidney disease ______	☐	☐
18.	liver disease or jaundice ______	☐	☐
19.	vertigo (e.g., "the room is spinning") ______	☐	☐
20.	thyroid, parathyroid disease, or calcium deficiency ______	☐	☐
21.	hormone deficiency or imbalance (e.g., polycystic ovarian syndrome) ______	☐	☐
22.	high cholesterol or taking statin drugs ______	☐	☐
23.	diabetes (HbA1c = ______) ______	☐	☐
24.	stomach or duodenal ulcer ______	☐	☐
25.	digestive or eating disorders (e.g., gastric reflux, bulimia, anorexia, celiac disease, Crohn's disease, or any inflammatory bowel disease) ______	☐	☐

		YES	NO
26.	osteoporosis/osteopenia or ever taken anti-resorptive medications (e.g., bisphosphonates) ______	☐	☐
27.	arthritis or gout ______	☐	☐
28.	autoimmune disease (e.g., rheumatoid arthritis, lupus, scleroderma) ______	☐	☐
29.	glaucoma ______	☐	☐
30.	contact lenses ______	☐	☐
31.	head or neck injuries ______	☐	☐
32.	epilepsy, convulsions (seizures) ______	☐	☐
33.	neurologic disorders (e.g., Alzheimer's disease, dementia, prion disease)	☐	☐
34.	viral infections (e.g., cold sores) bacterial infections (e.g., Lyme disease) ______	☐	☐
35.	any lumps or swelling in the mouth ______	☐	☐
36.	hives, skin rash, hay fever ______	☐	☐
37.	STI/STD/HPV ______	☐	☐
38.	hepatitis (type ____) ______	☐	☐
39.	HIV/AIDS ______	☐	☐
40.	tumor, abnormal growth ______	☐	☐
41.	radiation therapy ______	☐	☐
42.	chemotherapy, immunosuppressive medication ______	☐	☐
43.	difficulties with stress management ______	☐	☐
44.	psychiatric treatment, antidepressants, mood stabilizing medications	☐	☐
45.	concentration problems or ADD/ADHD ______	☐	☐
46.	alcohol/recreational drug use ______	☐	☐

ARE YOU:

		YES	NO
47.	presently being treated for any other illness ______	☐	☐
48.	aware of a change in your health in the last 24 hours (e.g., fever, chills, new cough, or diarrhea) ______	☐	☐
49.	taking medication for weight management ______	☐	☐
50.	taking dietary supplements, vitamins, and/or probiotics ______	☐	☐
51.	often exhausted or fatigued ______	☐	☐
52.	experiencing frequent headaches or chronic pain ______	☐	☐
53.	a smoker, smoked previously or other (e.g., smokeless tobacco, vaping, e-cigarettes, and cannabis) ______	☐	☐
54.	considered a touchy/sensitive person ______	☐	☐
55.	often unhappy or depressed ______	☐	☐
56.	taking birth control pills ______	☐	☐
57.	currently pregnant ______	☐	☐
58.	diagnosed with a prostate disorder ______	☐	☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections) ______________________

List all medications, supplements, vitamins, and/or probiotics taken within the last two years.

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature ______________________ Date ____________

Doctor's Signature ______________________ Date ____________

ASA ______ **(1-6)** ○ ○ ○

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