PATIENT REGISTRATION AND HEALTH QUESTIONNAIRE
For
Ingram Dental Clinic, P.C.

_____
Patient Name

_____ _____
Date of Birth Social Security #

Patient Phone #_____ Work # _____

_____
Person Responsible for Account

_____
Employed by

_____
Responsible party's Phone #

_____ _____
Spouse's Name Date of Birth

_____
Name of Dental Insurance Company

_____
Patient Address City Zip

E-mail Address: _____

Cell # _____ M / F (circle one)

_____
Responsible Party's Address City Zip

_____
Employer's Address City Zip

_____ _____
Social Security # Date of Birth

_____
Spouse's Employer Phone #

_____
Name of Policy Holder Policy Number

Name of Person who referred you to us? _____ Phone # _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Purpose of Consent: By signing this form I consent to Ingram Dental Clinic, P.C. the use and disclosure of my protected health and financial information to carry out treatment, payment activities (payment plan verification) and healthcare operations (insurance). I also give consent to Ingram Dental Clinic to contact me at any and all phone numbers and addresses for the purpose of carrying out treatment, payment activities and insurance.

Notice of Privacy Practices: I have had the opportunity to read Dr. Ingram's Notice of Privacy Practices before deciding whether to sign this consent. Dr. Ingram's notice provides a description of his treatment, payment activities, and healthcare operations, of the uses and disclosures he may make of your protected health and financial information. A copy of Dr. Ingram's Notice is posted on the bulletin board in the waiting room. We encourage you to read it carefully and completely before signing this consent. Dr. Ingram reserves the right to change his privacy practices as described in the Notice of Privacy Practices. If Dr. Ingram changes the Privacy Practices he will issue a revised Notice of Privacy Practices which will contain the changes. Those changes may apply to any of your protected health and financial information that Dr. Ingram maintains. You may obtain a copy of our Notice of Privacy Practices, by contacting our Office Manager Sandra.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Financial Arrangements: Unless prior arrangements have been made with our office manager, **the fee for services must be paid at the time the service is rendered.** We will be happy to fill out your insurance forms and will accept these completed forms as payment on your account. Any remaining balance will be due at the conclusion of each appointment. Please read Ingram Dental Clinic's Financial Policy and Option Pamphlet. We will verify and let you know if you qualify (pre-approve) for the Ingram Dental Payment Plan. I understand that I am financially responsible to Dr. Ingram for all of my family's individual charges incurred during the course of our treatment, even though I may have insurance or other third-party coverage. I recognize that the cost of this dental care may exceed the amount reimbursed by my Insurance Company. I promise to pay this amount when due. In the event of default, I recognize that legal proceedings may result. I agree to pay all costs of collection, past due interest, and/or attorney's fees.

_____ _____ _____
Signature Relationship to Patient Date

CONTINUED ON BACK

Patient Name: _____ MEDICAL HISTORY

It is important that I know about your dental and medical history. Permission is given to Dr. Ingram to obtain necessary medical/dental records or information. Any information that you give that Dr. Ingram obtains will be strictly confidential and will not be released to anyone without your written permission.

1. Please check any of the following you **HAVE** or **HAVE HAD**:

_____ Heart Trouble	_____ Abnormal Bleeding when cut
_____ Congenital Heart Defect	_____ Asthma or Emphysema
_____ Heart Valve Replacement	_____ Diabetes (Sugar)
_____ Infective Endocarditis	_____ Tuberculosis
_____ Cardiac Transplant	_____ Hepatitis or Jaundice
_____ Joint Replacement	_____ Arthritis
_____ High Blood Pressure	_____ Stroke
_____ Epilepsy/Seizures	_____ Tobacco (____ ppd / 1 can per _____), Vape( )e-cigarette
_____ Psychiatric Treatment	_____ Alcohol
_____ HIV Positive	_____ Blood Transfusion
_____ Sexually Transmitted Diseases	_____ Malignancies (Cancer) Location: _____
_____ Taken or taking an appetite suppressant such as Phen-Fen	

Other: _____

2. Have you ever **PREMEDICATED** with **ANTIBIOTICS** before any dental procedure, due to heart conditions, joint replacements, and/or other health conditions? (**yes** or **no**)
3. Do you take **Opiod Medications**? (**yes or no**). If so please list: _____
   If yes, do you have **NARCAN** (naloxone hydrochloride) available with you? (**yes or no**)
4. Name of Physician:_____Address: _____
5. List any "**Medicines**" or "**Drugs**" you are taking: _____
   _____
6. List any Medicines or Drugs that you are "**Allergic**" to: _____
   _____
7. Are you pregnant? _____ Due Date: _____
8. Is this your **FIRST** visit to Dr. Ingram's office? Yes or No
9. Purpose of this dental appointment: _____
10. Name of last Dentist seen: _____ Address: _____
11. Date and reason of last dental appointment: _____
12. Have you been Hospitalized or received medical treatment within the past five years? Yes or No
    Reason: _____
13. Who may we contact in case of an Emergency? _____ Phone: _____
14. I give Dr. Ingram and staff permission to perform any necessary medical emergency procedures.

_____ _____

Signature of Patient or Responsible Party Date