Patient Registration

Patient Information

First Name:______________________ Last Name:_______________________ Middle Initial:_____

Preferred Name/Nick Name:__________________________

Address:______________________________ City, State, Zip:______________________________

Phone Number:_________________

Birth Date:_____________________ Age:_____ Gender: ○ Male ○ Female

Referred By:______________________

Responsible Party/Parent /Legal guardian Information

First Name:______________________ Last Name:_______________________ Middle Initial:_____

Address:______________________________ City, State, Zip:______________________________

Phone #:___________________ Cell #:___________________ Work#:_______________ext._____

E-mail:____

Birth Date:_____________________ Gender: ○ Male ○ Female

Is the Insurance under this Parent/Legal Guardian? ○ Yes ○ No

If no, Please list the Parent/Legal Guardian the insurance is under below.

Responsible Party/Parent /Legal guardian Information

First Name:______________________ Last Name:_______________________ Middle Initial:_____

Address:______________________________ City, State, Zip:______________________________

Phone #:___________________ Cell #:___________________ Work #:____________________

Birth Date:_____________________ Gender: ○ Male ○ Female

Emergency Contact Information

Emergency Contact:_____________________

Phone #:______________________________

Relationship to Patient:__________________

Primary Insurance

Insured Name:______________________

Birth Date:_________________________

Soc. Sec. #:________________________

Insurance Co:_______________________

Address:___________________________

City, State, Zip:_____________________

Employer:__________________________

Secondary Insurance

Insured Name:______________________

Birth Date:_________________________

Soc. Sec. #:________________________

Insurance Co:_______________________

Address:___________________________

City, State, Zip:_____________________

Employer:__________________________

ATTENTION-PLEASE READ THE FOLLOWING CAREFULLY AND SIGN AT T HE BOTTOM.

*Please be advised if for any reason you/legal guardian cannot bring your child to their scheduled appointment, we MUST have a note signed by you/legal guardian stating we are able to treat you child in the caregivers presence. There are NO exceptions, and your child will not be seen without this note.

*If you need to cancel or reschedule we require a 24 hour notice, if no notice is given, your family account will be subjected to a $25 fee per child failed. We also reserve the right to not reschedule your child back.

*All payments are due upon service date. Any payment arrangements need to be made prior to day of appointment. All accounts past due 90 days will be submitted to collections.

Signature____ Date:___________________________

Dr. Kurt Halum, D.M.D.

MEDICAL HISTORY

Patient's Name -

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: ______

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: ______

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: ______

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: ______

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No ______

Are you on a special diet? ◯ Yes ◯ No ______

Do you use tobacco? ◯ Yes ◯ No ______

Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
- ☐ Pregnant/Trying to get pregnant?
- ☐ Nursing?
- ☐ Taking oral contraceptives?

Are you allergic to any of the following?
- ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics
- ☐ Other If yes, please explain: ______

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

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

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: ______

Comments: ______

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN ______ DATE ______

Kurt M. Halum D.M.D.

2303 45th Street, Highland, IN 46322

(219)924-5437

DIAGNOSTIC X-RAYS

A dental x-ray is a picture of parts of the teeth, bone and gum tissue that cannot be seen in a clinical examination of the mouth. The details shown on the film are essential in making an accurate diagnosis of your child's oral health. Without them, certain dental conditions can and will be missed. The American Academy of Pediatric Dentistry recommends radiographs and examinations every six months for children with a high risk of tooth decay.

Baby teeth have thin enamel, and cavities in baby teeth can spread quickly. Without x-rays we can only examine 60% of the tooth's surface and early evidence of tooth decay may not be detected until cavities are severe. X-rays can also show abscessed teeth, failure of teeth to form, developing unerupted teeth, fractures of tooth roots, tumors and cysts of the jaw, extra teeth that may be present in the jaw, and can also detect bone destruction associated with gum disease.

With contemporary safeguards, the amount of radiation received in a dental x-ray is very small. Our equipment is certified for precise dosage and minimal exposure time. The film we use is the fastest x-ray film made today, and children wear a protective lead apron to assure that your child receives a minimal amount of radiation exposure. In reality, taking periodic x-rays amounts to about the same amount of radiation exposure as one day in the sun!

The decision as to when to take x-rays are based on a number of findings, including but not limited to:

- The eruption pattern of your child's teeth
- The extent of decay in you child's mouth
- The presence of unusual pathology on you child's teeth or surrounding tissue
- Any history of injury to you child's mouth
- A family history of dental
- The presence or absence of fluoridated drinking water in you community

I, the undersigned have read and understand the above information and, (please check one)

____AGREE, Give consent for Diagnostic X-Rays, as recommended.

____Disagree, Release the Doctor or any member of the dental team from any responsibility resulting from refusal of Diagnostic X-rays as recommended.

Signed____

Date________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ('HIPPA'), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operation such as quality assessments and physician certifications.

I have received, read and understand you *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change it's *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operation. I also understand Dr. Halum is not required to agree to my requested restriction, but if Dr. Halum does agree then this office is bound to abide by such restrictions.

Print Patient Name______________________________________

Relationship to Patient__________________________________

Signature____

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

I request that all communications by Dr. Halum and his staff be handled in the following manner:

Written Communications Address to: ______________________________________

____

If the address provided above is not your home address or is not a street address, please provide us with a street address for purposes of ensuring payment.

Oral Communications: Home #______________________________________

May we leave a message ______ yes _______no

Work #______________________________________

May we leave a message ______ yes _______no

Cell # ______________________________________

May we leave a message _______yes ______ no

May we leave a message that you need premedication? _______yes ______ no

May we leave a message that you have an appointment? _______yes ______ no

Office Use Only

I attempted to obtain the patent's/guardian's signature in acknowledgment of this Notice of Privacy Practices acknowledgement, but was unable to do so as documented below.

Date: Initial: Reason: