

# DENTAL REGISTRATION AND HISTORY

(PLEASE PRINT)

Date \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

## PATIENT INFORMATION

Name \_\_\_\_\_  
Last Name First Name Middle Initial  
 SS/HIC/Patient ID # \_\_\_\_\_  
 Address \_\_\_\_\_ E-mail \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Sex ☐ M ☐ F Age \_\_\_\_\_ Birthdate \_\_\_\_\_  
☐ Married ☐ Widowed ☐ Single ☐ Minor  
☐ Separated ☐ Divorced ☐ Partnered for \_\_\_\_\_ years  
 Patient Employer/School \_\_\_\_\_ Occupation \_\_\_\_\_  
 Employer/School Address \_\_\_\_\_ Employer/School Phone (\_\_\_\_) \_\_\_\_\_  
 Whom may we thank for referring you? \_\_\_\_\_  
 In case of emergency who should be notified? \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

## PRIMARY INSURANCE

Person Responsible for Account \_\_\_\_\_  
Last Name First Name Middle Initial  
 Relation to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
 Address (If different from patient's) \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Person Responsible Employed by \_\_\_\_\_ Occupation \_\_\_\_\_  
 Business Address \_\_\_\_\_ Business Phone (\_\_\_\_) \_\_\_\_\_  
 Insurance Company \_\_\_\_\_  
 Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_  
 Names of other dependents covered under this plan \_\_\_\_\_

## ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No  
 Subscriber Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Relation to Patient \_\_\_\_\_  
 Address (If different from patient's) \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Subscriber Employed by \_\_\_\_\_ Business Phone (\_\_\_\_) \_\_\_\_\_  
 Insurance Company \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
 Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_  
 Names of other dependents covered under this plan \_\_\_\_\_

## ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_ and assign directly to  
Name of Insurance Company(ies)  
 Dr. \_\_\_\_\_ all insurance benefits, if any, otherwise payable to me for services rendered. I understand  
 that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.  
 The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and  
 their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This  
 consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative \_\_\_\_\_

Date \_\_\_\_\_

Please print name of Patient, Parent, Guardian or Personal Representative \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

# DENTAL HEALTH HISTORY

## (Confidential)

### DENTAL HISTORY

Reason for Today's Visit \_\_\_\_\_ Date of last dental care \_\_\_\_\_

Former Dentist \_\_\_\_\_ Date of last dental X-rays \_\_\_\_\_

Address \_\_\_\_\_

Check (✓) if you have had problems with any of the following

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Bad breath                    | <input type="checkbox"/> Grinding teeth                 | <input type="checkbox"/> Sensitivity to hot             |
| <input type="checkbox"/> Bleeding gums                 | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets          |
| <input type="checkbox"/> Clicking or popping jaw       | <input type="checkbox"/> Periodontal treatment          | <input type="checkbox"/> Sensitivity when biting        |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Sensitivity to cold            | <input type="checkbox"/> Sores or growths in your mouth |

How often do you floss? \_\_\_\_\_ How often do you brush? \_\_\_\_\_

### MEDICAL HISTORY

Physician's Name \_\_\_\_\_ Date of Last Visit \_\_\_\_\_

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine.) ☐ Yes ☐ No

Have you had any serious illnesses or operations? \_\_\_\_\_ If yes, describe \_\_\_\_\_

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate date(s) \_\_\_\_\_

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (✓) if you have or have had any of the following:

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Hepatitis             | <input type="checkbox"/> Scarlet Fever              |
| <input type="checkbox"/> Arthritis, Rheumatism   | <input type="checkbox"/> Cough, Persistent    | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Shortness of Breath        |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Cough up Blood       | <input type="checkbox"/> HIV/AIDS              | <input type="checkbox"/> Skin Rash                  |
| <input type="checkbox"/> Artificial Joints       | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Jaw Pain              | <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Epilepsy             | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> Back Problems           | <input type="checkbox"/> Fainting             | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Thyroid Problems           |
| <input type="checkbox"/> Blood Disease           | <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tobacco Habit              |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Headaches            | <input type="checkbox"/> Pacemaker             | <input type="checkbox"/> Tonsillitis                |
| <input type="checkbox"/> Chemical Dependency     | <input type="checkbox"/> Heart Murmur         | <input type="checkbox"/> Radiation Treatment   | <input type="checkbox"/> Tuberculosis               |
| <input type="checkbox"/> Chemotherapy            | <input type="checkbox"/> Heart Problems       | <input type="checkbox"/> Respiratory Disease   | <input type="checkbox"/> Ulcer                      |
| <input type="checkbox"/> Circulatory Problems    | <input type="checkbox"/> Hemophilia           | <input type="checkbox"/> Rheumatic Fever       | <input type="checkbox"/> Venereal Disease           |

### MEDICATIONS

List medications you are currently taking:

\_\_\_\_\_

\_\_\_\_\_

Pharmacy Name \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_

### ALLERGIES

- |  |                                      |
|--|--------------------------------------|
| <input type="checkbox"/> Aspirin                       | <input type="checkbox"/> Sulfa       |
| <input type="checkbox"/> Barbiturates (Sleeping pills) | <input type="checkbox"/> Latex _____ |
| <input type="checkbox"/> Codeine                       | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Local Anesthetic              | _____                                |
| <input type="checkbox"/> Penicillin                    |                                      |

### SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date \_\_\_\_\_ Signature \_\_\_\_\_



### **Financial Agreement and Consent to Treat**

Our goal is to provide the highest quality of dental care possible and to have clear communication of our financial and office policies.

All accounts are due and payable at the time of service. Payment Options: Cash, check, Mastercard, Visa, American Express, Discover/Novus and Care Credit.

Patients with Insurance: Dental insurance plans do not normally provide full coverage of your dental bill. Your dental coverage is a contract between you and your insurance company, and while we cooperate to the fullest in expediting your claim, you are ultimately responsible for your own account. The PATIENT is responsible for the ESTIMATED non covered portions, procedures and/or deductibles at the time of service. If your insurance has not paid within 60 days from the date of service, we will look to you for prompt payment of the account. All costs for collection of the account, should collection procedures and/or small claims court become necessary, will be passed on to the patient and/or the responsible party. Parents not accompanying their child to an appointment must make prior arrangements for payment.

18% annual interest is charged for any unpaid balance. A \$15 fee is charged for payments not made before the due date. There is a \$30.00 processing charge for returned checks.

Because instruments, chairs, and personnel are reserved exclusively for your appointment, there is a \$50 charge for changed or broken appointments less than 48 hours in advance.

During the course of treatment, I may undergo procedures in all phases of dentistry including periodontics (gum treatment and surgery), oral surgery, endodontics (root canals), fixed and removable prosthodontics (crowns, bridges and dentures), implant dentistry, restorative dentistry, temporomandibular disorder treatment, sleep apnea treatment, oral pathology, pediatric dentistry and radiography. I will provide a thorough and complete medical history, supply a full list of my medications with dosages and consent to my dentist communicating with other medical practitioners to inquire about any aspect of my health history. I understand no guarantees can be made about treatment outcomes, restoration longevity, or prognosis, I understand that any branch of medicine, including dentistry, can involve unanticipated results. I am welcome to ask questions about any aspects of my dental care and I am responsible for clarifying any aspects of treatment I am unsure about.

I, \_\_\_\_\_, consent to be a patient at the above named office and agree to radiographic and clinical examination. I also understand and agree to the financial terms as stated above.

Signature \_\_\_\_\_ Date \_\_\_\_\_

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### **LUKER DENTAL**

1829 56<sup>th</sup> Ave. Suite B  
Greeley, CO 80634

Phone: 970.351.0400  
Fax: 970.301.4116

lukerdental@gmail.com  
lukerdental.com



## 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 review it carefully. The privacy of your health information is important to us.

### Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect 04/14/2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

### Uses and Disclosures of Health Information

We use and disclose health information about you for treatment, payment and healthcare operations. For Example:

**Treatment:** We may use or disclose your health information to a physician or any other healthcare provider providing treatment to you.

**Payment:** We may use or disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations:** We may use or disclose your health information in connection with our healthcare operations.

Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**Your Authorization:** In addition to our use of our health information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

**To Your Family and Friends:** We must disclose your health information to you, as described in the patient rights section of this notice. We may disclose your health information to a family member, friend or any other person to the extent necessary to help with your healthcare or with your payment for your healthcare, but only if you agree that we may do so.

**Persons Involved in Care:** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the persons involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x rays, or other similar form of health information.

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**Marketing Health Related Service:** We will not use your health information for marketing communications without your written authorization.

**Required by Law:** We may disclose your health information when we are required to do so by law/.

**Abuse of Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert serious threat to your health or safety or the health or safety of others.

**National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institute or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters)

## **Patient Rights**

**Access:** You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you requested unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this notice. We will charge you a reasonable cost based fee for expenses such as copies and staff time. If you request copies, we will charge you \$\_\_\_ for each page and \$\_\_\_ per hour for staff time to locate and copy your health information and postage if you want the copies mailed to you, if you request an alternative format, we will charge a cost based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you requested this accounting more than once in a 12 month period, we may charge you a reasonable, cost based fee for responding to these additional requests.

**Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restriction, but if we do, we will abide by our agreement (except in an emergency).

**Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing) Your request must specify the alternative means or location you request.

**Amendment:** You have the right to request that we amend your health information. (your request must be in writing, and it must explain why the information should be amended) We may deny your request under certain circumstances.

**Electronic Notice:** If you receive this Notice on our website or by electronic mail (email), you are entitled to receive this notice in written form.

## **Questions and Complaints**

If you want more information about our privacy rights, 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 use of disclosure of your health information or to have us communicate with your by alternative means or at alternative location, you may complain to us using the contact information listed at the end of this notice. You also may submit a written complaint to the US Department of Health and Human Services. We will provide you with the address to file your complaint with the US Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in anyway if you choose to file a complaint with us or with the US department of Health and Human Services.

Contact Officer: Dr. David Luker

Telephone: 970-351-0400

E-mail: [Lukerdental@gmail.com](mailto:Lukerdental@gmail.com)

Address: 1829 56<sup>th</sup> Ave, Suite B Greeley Colorado, 80634



## Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy of these offices' Notice of Privacy Practices.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

### Release of Information to Spouse/Family

I authorize the release of information including diagnosis, records examination rendered to me and claims information to: ( ) \_

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

I do not authorize the release of my information to anyone ( )

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

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