ACCOUNT REGISTRATION

Please Print Legibly

DATE _____

PERSON RESPONSIBLE FOR ACCOUNT

Last Name	Title (Mr./Mrs., etc.)	First Name	M.I.	Sex	Telephone Numbers Home / Office

Address	City	State	Zip Code	Birth date

Employer Name	Employer Address	City	State	Patient Number

Who Can We Thank for Your Referral?	I Accept Responsibility for the Account Signature of Responsible Person, Spouse or other Guarantor	Social Security Number

SPOUSE INFORMATION

Last Name	Title (Mr./Mrs., etc.)	First Name	M.I.	Sex	Telephone Numbers Home / Office

Address	City	State	Zip Code	Birth date

Employer Name	Employer Address	City	State	Social Security Number

DEPENDENT INFORMATION

Last Name (if same-put "Same")	First Name	M.I.	Sex	Birth date	Patient Number
1.					
2.					
3.					
4.					

INSURANCE INFORMATION

Responsible Person's Insurance Information			**Spouse's Insurance Information**		
Carrier (Insurance Company) Name and Address			Carrier (Insurance Company) Name and Address		
Who is Covered? (Circle) Husband Wife Dependents 1 2 3 4	S.S. No. of Insured	Policy No. (if any)	Who is Covered? (Circle) Husband Wife Dependents 1 2 3 4	S.S. No. of Insured	Policy No. (if any)
Employee No. (if any)	Group Name (if any)	Group No. (if any)	Employee No. (if any)	Group Name (if any)	Group No. (if any)

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my doctor to submit claims for benefits for services rendered or to be rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents and that I will be bound by the signature as though the undersigned had personally signed the particular claim.

Authorized Signature of Covered Person/Employee Date

Authorized Signature of Covered Person/Employee Date

I Hereby Authorize Payment Directly to the Doctor of the Group Insurance Benefits Otherwise Payable to Me.

Authorized Signature of Covered Person/Employee Date

Authorized Signature of Covered Person/Employee Date

NOTIFY IN CASE OF EMERGENCY (OTHER THAN SPOUSE)

Name	Address	Telephone No.	Relationship

HEALTH HISTORY

A MESSAGE ABOUT HISTORIES AND DENTISTRY

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 that you will be receiving.

Your dentist is legally obligated to ask the following questions. Thank you for answering them.

GENERAL HEALTH INFORMATION

Please print legibly

1. Name (Patient) :_____ Birth date: _____
2. Physician's Name: _____ Location: _____
3. Are you under the care of a physician for any illness or health problem? ..... YES NO
4. Has your blood pressure been checked within the last year? ..... YES NO
5. Have you received blood within the past year? ..... YES NO
6. Are you in good health now? ..... YES NO
7. When did you last receive a complete physical examination? _____

HEALTH CONDITIONS THAT RELATE TO DENTAL TREATMENT

1. Do you or have you had any of the following health conditions?

a. Rheumatic Heart Disease ..... YES NO
b. Rheumatic Fever ..... YES NO
c. Congenital Heart Lesions ..... YES NO
d. Artificial Joint ..... YES NO
e. Congenital Heart Disease ..... YES NO
f. Heart Murmur ..... YES NO
g. Mitral Valve Prolapse ..... YES NO
h. Open Heart Surgery ..... YES NO
i. Other Major Surgery ..... YES NO
j. Fainting Spells ..... YES NO
k. Seizures ..... YES NO
l. Diabetes ..... YES NO
m. Kidney Trouble ..... YES NO
n. Tuberculosis ..... YES NO
o. Stomach or Intestinal Ulcers ..... YES NO
p. High Blood Pressure ..... YES NO
q. Blood Disorders such as Anemia ..... YES NO
r. Abnormal Amount of Bleeding ..... YES NO
s. HIV Positive or AIDS ..... YES NO
t. Hepatitis, Jaundice or Liver Disease ..... YES NO
u. Sexually Transmitted Disease ..... YES NO

2. Have you had radiation therapy? ..... YES NO
3. Do you use tobacco in any form?? ..... YES NO
4. Do you have a heart Pacemaker?? ..... YES NO
5. Are you allergic to anything other than drugs, such as dust, or rubber?? ..... YES NO
6. If you are a woman – are you pregnant?? ..... YES NO
7. Do you have any disease, condition or handicap not listed above that you should mention?? ..... YES NO

If so, please explain: _____

DRUGS AND MEDICATION

1. Are you taking any over-the-counter drugs or prescription medications? If so, please complete the following information:

Name of drug or medications	The condition it is taken for

2. Have you had any allergies or any adverse side effects to any drug or medications such as novocaine, zylocaine, aspirin, penicillin, codeine, sulfa, etc.? If so, please complete the following information:

Name of medications	The condition it is taken for

Authorize the use of **NITROUS OXIDE** Yes No

Signature: _____ Relationship: _____ Date: _____

DENTAL HISTORY

GENERAL DENTAL INFORMATION

1. Previous Dentist _____ Period of Treatment _____
2. Address _____ Phone _____
3. Other Dentist _____ Specialty _____
4. Last Dental Visit _____ Last Full-Mouth X-Rays _____ Last Complete Dental Exam _____
5. What is your immediate dental concern? _____
6. Is there a reason you are changing dentist? ..... YES NO If yes, please explain: _____

DENTAL CONDITIONS

1. Do you or have you had any of the following health conditions?

a. Bleeding, Sore Gums ..... YES NO
b. Unpleasant Taste/Bad Breath ..... YES NO
c. Loose Teeth ..... YES NO
d. Periodontal (Gum) Treatment ..... YES NO
e. TMJ Treatment ..... YES NO
f. Clicking/Popping Jaw ..... YES NO
g. Clenching Grinding ..... YES NO
h. Sensitive Teeth ..... YES NO
i. Orthodontic Treatment (Braces) ..... YES NO
j. Nitrous Oxide Sedation (Gas) ..... YES NO
k. Dentures - Full or Partial ..... YES NO
l. Swelling/Tumors ..... YES NO

CONSENT

TREATMENT AUTHORIZATION & ACKNOWLEDGEMENT

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic acids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform only and all forms of treatment, medication, and

therapy that may be indicated in connection with (name of patient) _____ and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk including potential short or long term parasthesia. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 1 1/2% finance charge (18% annually) will be added to any balance over 30 days. In the event of default, I (we) promise to pay 18% of the indebtedness, together with such collection costs and reasonable attorney fees as amy be required to effect collection of this note.

Signature _____ Date _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

ROBERT J. AHERN, D.D.S., P.C.
1325 HOVER ST., SUITE 103
LONGMONT, COLORADO 80501
Telephone (303) 776-3018
Fax (303) 776-3409
Email rjadds@gmail.com

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

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

I have received, read and understand your *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 its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private 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 operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason: