

## Patient Registration

### Patient Information

Name: First \_\_\_\_\_ MI\_\_ Last \_\_\_\_\_  
Preferred Name \_\_\_\_\_  
Address \_\_\_\_\_  
City/State/Zip \_\_\_\_\_  
Home # \_\_\_\_\_ Mobile # \_\_\_\_\_ Work # \_\_\_\_\_  
E-Mail Address \_\_\_\_\_  
SS# \_\_\_\_\_ Birth Date \_\_\_\_\_  
Driver's License # \_\_\_\_\_  
Sex: Male \_\_\_ Female \_\_\_ Other \_\_\_  
Status: Married \_\_\_ Single \_\_\_ Minor \_\_\_  
Employer/School \_\_\_\_\_  
Occupation \_\_\_\_\_  
Spouse/Domestic Partner \_\_\_\_\_  
SS# \_\_\_\_\_ Birth Date \_\_\_\_\_  
Home # \_\_\_\_\_ Mobile # \_\_\_\_\_ Work # \_\_\_\_\_  
Employer/School \_\_\_\_\_

Whom may we thank for referring you?  
\_\_\_\_\_

### E-mail and Texting Correspondence Disclosure

Aspire Dental sends all appointment reminders for cleanings, check-ups, appointments and other communication via email and phone correspondence. We also offer text messaging appointment reminders. I understand that certain charges may apply according to my internet/phone carriers and that Aspire Dental is not responsible for such charges.

I understand that I can opt out of e-mail communication and can opt in to text communication.

\_\_\_\_\_  
Signature of Patient/Guardian

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

### Dental Insurance

Primary Insurance Company \_\_\_\_\_  
Subscriber's Name \_\_\_\_\_  
SS# \_\_\_\_\_ Birth Date \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_  
ID# \_\_\_\_\_  
Group # \_\_\_\_\_  
Insurance Phone # \_\_\_\_\_  
  
Secondary Insurance Company \_\_\_\_\_  
Subscriber's Name \_\_\_\_\_  
SS# \_\_\_\_\_ Birth Date \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_  
Secondary Insurance \_\_\_\_\_  
ID# \_\_\_\_\_  
Group # \_\_\_\_\_  
Insurance Phone # \_\_\_\_\_

### Assignment and Release of Insurance Benefits

I certify that I, and/or my dependent(s), have insurance coverage with the listed insurance company, or companies, and assign directly to Dr. Lisa Kakishita DMD LLC DBA Aspire Dental 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.

Aspire Dental may use my health care information and may disclose such information to the above-named Insurance companies and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

\_\_\_\_\_  
Signature of Patient/Guardian

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

## Emergency Contact

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Home # \_\_\_\_\_ Work # \_\_\_\_\_ Mobile # \_\_\_\_\_

## Financial Agreement

Payments may be made by cash, check, credit card, or Care Credit. We reserve the right to charge a \$25.00 fee for all checks returned for non-sufficient funds. **Your balance is due at the time services are rendered. A penalty for late payments of 1.75% per month (21% per annum) will be added to all accounts 30 days past due. Terms: Net 30 days.**

If you have dental insurance, as a courtesy, we will bill your insurance carrier directly. Dental insurance rarely covers 100% of services rendered; therefore please be prepared to pay your co-pay at each visit. Aspire Dental will provide an estimate for co-pays prior to your visit. This is an estimate only and you will be responsible for any amounts not reimbursed by your dental insurance. Patients are ultimately responsible for knowing their insurance plans.

Scheduled appointments are reserved specifically for you. If you need to change an appointment, please contact the office with at least 48 hours notice. **There will be a \$50.00 fee for appointments cancelled without 48-hour notice.** We realize that time is very important to you, and we make every effort to stay prompt. We ask that you have the same consideration by being on time for your appointments.

\_\_\_\_\_  
Patient/Guardian Relationship to Patient Date

## Health History

**Patient Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

Reason for today's visit? \_\_\_\_\_  
 Former Dentist \_\_\_\_\_ City/State \_\_\_\_\_ Date of last exam, cleaning and x-rays \_\_\_\_\_  
 How often do you floss? \_\_\_\_\_ How often do you brush? \_\_\_\_\_  
 Do you have dental anxiety? Please explain \_\_\_\_\_

**Please circle Y for yes or N for no to indicate if you have had any of the following:**

Bad Breath	Y	N	Fingernail biting	Y	N
Dry Mouth	Y	N	Tobacco use (Type _____)	Y	N
Mouth Breathing	Y	N	Foreign objects-piercings in or around the mouth	Y	N
Bleeding gums	Y	N	Food collection between teeth	Y	N
Swollen or tender gums	Y	N	Broken teeth or fillings	Y	N
Sore or growths in mouth	Y	N	Mouth pain when brushing	Y	N
Periodontal(gum) treatment or surgery	Y	N	Sensitivity to cold	Y	N
Loose teeth	Y	N	Sensitivity to heat	Y	N
Burning sensation on tongue	Y	N	Sensitivity to sweets	Y	N
Clicking or popping jaw	Y	N	Sensitivity to biting	Y	N
Jaw pain or tiredness	Y	N	Wisdom teeth removal	Y	N
Grinding or clenching teeth	Y	N	Orthodontic treatment	Y	N
Pain around ear	Y	N	Orthodontic retainers please specify _____	Y	N

## Medical History

Physician's Name \_\_\_\_\_ Date of last visit \_\_\_\_\_

If female, are you pregnant? \_\_\_\_\_ Weeks \_\_\_\_\_ Due Date \_\_\_\_\_

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

**Please circle Y for yes or N for no to indicate if you have had any of the following:**

Acid Reflux/GERD/Heart Burn	Y	N	Emphysema	Y	N	Radiation Treatment	Y	N
AIDS/HIV	Y	N	Epilepsy	Y	N	Respiratory Disease	Y	N
Anemia	Y	N	Fainting or dizziness	Y	N	Rheumatic Fever	Y	N
Arthritis, Rheumatism	Y	N	Glaucoma	Y	N	Scarlet Fever	Y	N
Artificial Heart Valves	Y	N	Headaches	Y	N	Sinus Trouble	Y	N
Artificial Joints	Y	N	Heart Murmur	Y	N	Skin Rash	Y	N
Asthma	Y	N	Heart Problems	Y	N	Special Diet	Y	N
Back Problems	Y	N	Hepatitis Type _____	Y	N	Stroke	Y	N
Bleeding Problems	Y	N	Herpes	Y	N	Swollen Feet or Ankles	Y	N
Blood Disease	Y	N	High Blood Pressure	Y	N	Swollen Neck Glands	Y	N
Cancer	Y	N	Jaundice	Y	N	Thyroid Problems	Y	N
Chemical Dependency	Y	N	Kidney Disease	Y	N	Tonsillitis	Y	N
Chemotherapy	Y	N	Liver Disease	Y	N	Tuberculosis	Y	N
Circulatory Problems	Y	N	Low Blood Pressure	Y	N	Tumor or growth	Y	N
Cortisone Treatments	Y	N	Mitral Valve Prolapse	Y	N	Ulcer	Y	N
Cough, persistent or bloody	Y	N	Pacemaker	Y	N	Sexually Transmitted Infection	Y	N
Diabetes	Y	N	Psychiatric Care	Y	N	Weight Loss, unexplained	Y	N

Other things to know that aren't listed:

### Medications

List any medications or herbal supplements you are currently taking and why:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Pharmacy Name \_\_\_\_\_  
 Phone \_\_\_\_\_

### Allergies

\_\_\_ No Known Drug Allergy  
 \_\_\_ Aspirin                      \_\_\_ Barbiturates(sleeping pills)  
 \_\_\_ Codeine                      \_\_\_ Iodine  
 \_\_\_ Latex                          \_\_\_ Local Anesthetic  
 \_\_\_ Penicillin                      \_\_\_ Sulfa  
 Other \_\_\_\_\_

## Notice Of Privacy Practices

Aspire Dental and its staff are dedicated to serving their patients with professionalism and care while, at all times, protecting the privacy and security of all health information. During the course of treatment it may be necessary to share information with health care professionals or business associates. The following are examples of instances where information may be shared:

- Radiographs and treatment information may be forwarded to specialists if a referral is needed.
- Disclosure of health or dental information when required by law.
- Forwarding radiographs and chart notes to your insurance company for payment purposes.
- For collection purposes, payment history or financial agreements may be forwarded to the proper agency for collecting.
- Disclosure of health information to provide you with reminders such as voicemail messages, postcards, letters, e-mails, or text messaging.

### HIPAA DISCLOSURE ACKNOWLEDGEMENT

I understand and agree to the above disclosures and have had a chance to ask questions regarding this notice. I understand that a policy is available for me to read and I may receive a copy for my records if necessary.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
 Doctor Signature \_\_\_\_\_ Date \_\_\_\_\_  
 Hygienist Signature \_\_\_\_\_ Date \_\_\_\_\_ Staff Initial \_\_\_\_\_