Patient Registration

Patient Information

Name: First _____ MI_ Last _____
Preferred Name _____
Address _____
City/State/Zip _____
Home # _____ Mobile # _____
E-Mail Address_____
SS# _____ Birth Date _____
Driver's License #_____
Sex: __Male __Female Preferred Pronouns: _____
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?

_____

Email 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 copay 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 canceled 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 brush? _____ How often do you floss? _____

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	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	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	Epilepsy	Y	N	Respiratory Disease	Y	N
AIDS/HIV	Y	N	Fainting or dizziness	Y	N	Rheumatic Fever	Y	N
Anemia	Y	N	Glaucoma	Y	N	Scarlet Fever	Y	N
Arthritis, Rheumatism	Y	N	Headaches	Y	N	Sexually Transmitted Infection	Y	N
Artificial Heart Valves	Y	N	Heart Attack	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	Sleep Apnea, Snoring, Sleep Issues	Y	N
Back Problems	Y	N	Hepatitis Type _____	Y	N	Special Diet, Type _____	Y	N
Bleeding Problems	Y	N	Herpes	Y	N	Stroke	Y	N
Blood Disease	Y	N	High Blood Pressure	Y	N	Surgeries: _____	Y	N
Cancer	Y	N	Jaundice	Y	N	Swollen Feet or Ankles	Y	N
Chemical Dependency	Y	N	Kidney Disease	Y	N	Swollen Neck Glands	Y	N
Chemotherapy	Y	N	Liver Disease	Y	N	Thyroid Problems	Y	N
Circulatory Problems	Y	N	Low Blood Pressure	Y	N	Tonsillitis	Y	N
Cortisone Treatments	Y	N	Mitral Valve Prolapse	Y	N	Tuberculosis	Y	N
Cough, persistent or bloody	Y	N	Pacemaker	Y	N	Tumor or Growth	Y	N
Diabetes	Y	N	Psychiatric Care, Type _____	Y	N	Ulcer	Y	N
Emphysema	Y	N	Radiation Treatment	Y	N	Weight Loss, unexplained	Y	N

Other Health Issues Not 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