Larry Lee Chabot, D.D.S.

Patient Registration

Patient Information

Date _____

Patient's Name _____ (Last / First / Middle)

Address _____ (Street / City / State / Zip)

Home Phone _____ Birthdate _____ Age _____ Social Security # _____

Cell Phone _____ Work Phone _____

Sex: M or F Marital Status _____ Are you a full time student? _____

If patient is a minor, give parent's or guardian's name _____

Whom may we thank for referring you to our office? _____

Email Address _____

Responsible Party Information

Name _____ (Last / First / Middle) _____ Marital Status

Residence _____ (Home Street Address / City / State / Zip)

Mailing Address _____ (Street / City / State / Zip)

Home Phone _____ Cell Phone _____

Driver's License _____ Social Security _____

Birthdate _____ Relationship to Patient _____

Employer _____ Work Phone _____

Insurance Information

Insured's Name _____ Insured's Soc. Sec.# _____

Insurance Company _____ Group No. _____ ID# _____

Insurance Co. Address _____

Insurance Telephone # _____ Insured's Employer _____

Do you have double coverage ❑ Yes ❑ No If yes, complete the following: _____

Insured's Name _____ Insured's Soc. Sec.# _____

Insurance Company _____ Group No. _____ ID# _____

Insurance Co. Address _____

Insurance Telephone # _____ Insured's Employer _____

Local Emergency Contact

Name _____ Relationship _____

Phone _____

CONSENT: The undersigned hereby authorizes Office Staff to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Office Staff to perform any and all forms of treatment, medication, and therapy, that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, the undersigned, due and payable at the time services are rendered. I also assign all insurance benefits to the Doctor.

PATIENT SIGNATURE (Parent or Guardian of Child) _____ Date: _____ Reviewed by: _____

MEDICAL HISTORY

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: _____

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

_____

_____

Women: Are you

Pregnant/Trying to get pregnant? ❑ Yes ❑ No Taking oral contraceptives? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No

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

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

_____

DENTAL HISTORY

Reason for today's visit _____

Former Dentist _____ City/State _____

Date of last dental visit _____ Date of last dental X-rays _____

Check if you have had any of the following:

___ Bad Breath
___ Bleeding gums
___ Unpleasant taste
___ Food Impaction
___ Smoking or tobacco use

Tooth sensitivity to:
___ Cold
___ Hot
___ Sweets
___ Biting

___ Clicking or popping jaw
___ Pain around jaw or ear
___ Clenching or grinding
___ Dry mouth
___ Burning sensation on tongue
___ Blisters on lips or mouth
___ Swelling or lumps in mouth
___ Loose teeth or broken fillings
___ Oral habits/ Fingernail biting, cheek biting, etc.

___ Mouth pain, brushing
___ Gums swollen or tender
___ Orthodontic treatment
___ Oral surgery
___ Periodontal treatment

How often do you brush? _____

How often do you floss? _____

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 _____

LARRY LEE CHABOT, D.D.S.

Brassfield Office Park
3201 Brassfield Road, Suite 100
Greensboro, NC 27410
(336)288-0542

Notice of Privacy Practices
Patient Acknowledgement

Patient Name: _____ Date of Birth: _____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail that uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
  - The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
  - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
  - The right to receive confidential communications of protected health information.
  - The right to inspect and copy protected health information.
  - The right to amend protected health information.
  - The right to receive an accounting of disclosures of protected health information.
  - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Signature: _____ Date: _____

Relationship to patient (if signed by a personal representative of patient): _____

Release of Information

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information.
This information may be released to

❑ My spouse ❑ My children ❑ Other ❑ Don't release this information to anyone

If "other", please inform their name and address

_____

This release of Information will remain in effect until terminated by me in writing.

LARRY LEE CHABOT, D.D.S.

Brassfield Office Park ♦ Madison Building
3201 Brassfield Road, Suite 100
Greensboro, NC 27410

FINANCIAL POLICY

Payment in full, less insurance is expected at time of service unless prior arrangements have been made.

As a courtesy, we are happy to bill your insurance company. However, you are ultimately responsible for any amounts not covered by insurance. We try our best to estimate what your insurance will pay for procedures but actual payments received from the companies may be higher or lower than estimated. Please remember that insurance is a benefit and not a guarantee for dental work.

A service charge of 1.5% per month will be charged on all unpaid balances exceeding 30 days. In the event that your account must be sent to collections for non-payment, you will also be responsible for all cost of collections, court fees and attorney fees. **A $25 service fee will be added to your account for all returned checks.**

APPOINTMENT CANCELLATION POLICY

We strive to have timely appointments available to patients that need to be seen quickly. Therefore, **we need to know as soon as possible if you will be unable to keep your appointment** so that we may offer that time to someone who has an immediate need. Missed appointments not only create an inconvenience to us and other patients, but also put a financial burden on our practice when we keep staff and other resources available for appointments that are not kept. Interruptions in scheduled treatment can, ultimately affect your treatment options and outcome as well. As a courtesy to you, a confirmation call is made.

There will be a $50/per hour fee accessed for an appointment cancelled with less than 24 hour notice.

Certainly emergencies arise and we do not wish to penalize patients for unavoidable situations. However, we do want to discourage repeated abuse of our scheduling process, which is ultimately unfair to those patients who are diligent about keeping their appointments.

I have read and understand the above information reguarding the office policies and agree to the terms.

Sign _____ **Date** _____