Patient Registration

Patient Information

First Name:_____ Last Name:_____ Middle Initial:___

Preferred Name/Nick Name:_____

Address:_____ City, State, Zip:_____

Phone Number:_____

Birth Date:_____ Age:____ Gender: ○ Male ○ Female

Referred By:_____

Responsible Party/Parent /Legal guardian Information

First Name:_____ Last Name:_____ Middle Initial:___

Address:_____ City, State, Zip:_____

Phone #:_____ Cell #:_____ Work#:_____ext.____

E-mail:_____

Birth Date:_____ Gender: ○ Male ○ Female

Is the Insurance under this Parent/Legal Guardian? ○ Yes ○ No

If no, Please list the Parent/Legal Guardian the insurance is under below.

Responsible Party/Parent /Legal guardian Information

First Name:_____ Last Name:_____ Middle Initial:____

Address:_____ City, State, Zip:_____

Phone #:_____ Cell #:_____ Work #:_____

Birth Date:_____ Gender: ○ Male ○ Female

Emergency Contact (Non Parent/Guardian)

Emergency Contact:_____

Phone #:_____

Relationship to Patient:_____

Primary Insurance

Insured Name:_____

Birth Date:_____

Soc. Sec. #:_____

Insurance Co:_____

Address:_____

City, State, Zip:_____

Employer:_____

Secondary Insurance

Insured Name:_____

Birth Date:_____

Soc. Sec. #:_____

Insurance Co:_____

Address:_____

City, State, Zip:_____

Employer:_____

ATTENTION-PLEASE READ THE FOLLOWING CAREFULLY AND SIGN AT T HE BOTTOM.

*Please be advised if for any reason you/legal guardian cannot bring your child to their scheduled appointment, we MUST have a note signed by you/legal guardi stating we are able to treat you child in the caregivers presence. There are NO exceptions, and your child will not be seen without this note.

*If you need to cancel or reschedule we require a 24 hour notice, if no notice is given, your family account will be subjected to a $25 fee per child failed. We also reserve the right to not reschedule your child back.

*All payments are due upon service date. Any payment arrangements need to be made prior to day of appointment. All accounts past due 90 days will be submi to collections.

Signature_____ Date:_____

Dr. Kurt Halum, D.M.D.

MEDICAL HISTORY

Patient's Name -

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 you will receive. Thank you for answering the following questions.

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: _____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____

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

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No

Are you on a special diet? ◯ Yes ◯ No

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Women: Are you

☐ Pregnant/Trying to get pregnant? ☐ Nursing?

☐ Taking oral contraceptives?

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

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

Mental/Physical Disabilities: _____

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 _____

Kurt M. Halum D.M.D.

2303 45th Street, Highland, IN 46322

(219)924-5437

DIAGNOSTIC X-RAYS

A dental x-ray is a picture of parts of the teeth, bone and gum tissue that cannot be seen in a clinical examination of the mouth. The details shown on the film are essential in making an accurate diagnosis of your child's oral health. Without them, certain dental conditions can and will be missed. The American Academy of Pediatric Dentistry recommends radiographs and examinations every six months for children with a high risk of tooth decay.

Baby teeth have thin enamel, and cavities in baby teeth can spread quickly. Without x-rays we can only examine 60% of the tooth's surface and early evidence of tooth decay may not be detected until cavities are severe. X-rays can also show abscessed teeth, failure of teeth to form, developing unerupted teeth, fractures of tooth roots, tumors and cysts of the jaw, extra teeth that may be present in the jaw, and can also detect bone destruction associated with gum disease.

With contemporary safeguards, the amount of radiation received in a dental x-ray is very small. Our equipment is certified for precise dosage and minimal exposure time. The film we use is the fastest x-ray film made today, and children wear a protective lead apron to assure that your child receives a minimal amount of radiation exposure. In reality, taking periodic x-rays amounts to about the same amount of radiation exposure as one day in the sun!

The decision as to when to take x-rays are based on a number of findings, including but not limited to:

- The eruption pattern of your child's teeth
- The extent of decay in you child's mouth
- The presence of unusual pathology on you child's teeth or surrounding tissue
- Any history of injury to you child's mouth
- A family history of dental
- The presence or absence of fluoridated drinking water in you community

I, the undersigned have read and understand the above information and, (please check one)

____AGREE, Give consent for Diagnostic X-Rays, as recommended.

____Disagree, Release the Doctor or any member of the dental team from any responsibility resulting from refusal of Diagnostic X-rays as recommended.

Signed_____

Date_____

Acknowledgment of Receipt of Notice of Privacy Practices and HIPAA Non-Secure Communication Consent Form

Patient Name:	**Date of Birth:**
Patient Name:	**Date of Birth:**
Patient Name:	**Date of Birth:**
Patient Name:	**Date of Birth:**
Patient Name:	**Date of Birth:**

This consent form allows Kurt M. Halum, DMD, PC to use and disclose information about me protected under the Health Insurance Portability and Accountability Act of 1996. This information may be used or disclosed to carry out treatment, payment or health care operations.

Kurt M. Halum, DMD, PC has provided me with a Notice of Privacy Practices, which more completely describes such uses and disclosures. It provided this notice prior to my signing this form in accordance with my right to review its practices before signing consent.

I understand that the terms of the Notice of Privacy Practices may change and that I may obtain revised notices by contacting the Privacy Officer at Kurt M. Halum, DMD, PC.

____ Initial I hereby authorize Kurt M. Halum, DMD, PC to use unsecured email and mobile phone test messaging to transmit to me the following protected health information: 1) Information related to the scheduling of appointments; and, 2) Information related to billing and payment.

____ Initial I hereby authorize that Kurt M. Halum, DMD, PC may leave messages on my voicemail to confirm appointments, and/or may speak with other members of my household and leave messages with them regarding my appointments.

__ Email __ Home Phone __ Office Phone __ Cell Phone

____ Initial I hereby authorize that Kurt M. Halum, DMD, PC may disclose my health information to any person(s) who accompany me to my appointment, and are present with me in the office while I meet with my dentist and staff.

____ Initial I hereby authorize that Kurt M. Halum, DMD, PC may disclose my personal health information to the person who I have listed as my emergency contact.

____ Initial I hereby authorize that Kurt M. Halum, DMD, PC may disclose my personal health information to the following person(s):

Name	Telephone Number	Relationship to Patient

I understand that at any time I have the right to revoke this consent provided that I do so in writing, but that Kurt M. Halum, DMD, PC services may still use information to complete any actions that it began prior to my revoking consent and which rely on my protected health information. I understand that Kurt M. Halum, DMD, PC may refuse service if I revoke this consent.

I understand that I have the right to request – now and in the future – how protected health information is used or disclosed to carry out treatment, payment and health care operations, and must be provided by me in writing. I understand that while Kurt M. Halum, DMD, PC is not required to agree to my requested restrictions, if it does agree, it is bound by that agreement.

By my signature below, I affirm the above information.

Signature of Patient _____ Date: _____

Signature of Parent (if minor) / Authorized Representative _____ Date: _____