Welcome to LARRIMORE FAMILY DENTISTRY

Heather Larrimore, D.M.D.

PATIENT REGISTRATION

Date: _____ (PLEASE PRINT) Home Phone (____)_____

Patient _____
Last Name First Name Middle Initial Preferred Name

Street Address _____City_____State _____Zip_____

Email Address_____Cell Phone (____)_____
Do you prefer to receive your calls at your: ___Home ___Cell ___Work ___Other
Sex ___M ___F Age____ Date of Birth _____ ___Married ___Widowed ___Single ___Minor
___Separated ___Divorced ___Partnered for __Yrs

If Student, Name of School/College _____City_____St_____ PT___FT____

Patient Employer_____Occupation_____

Business Address_____Business Phone (___)_____

Spouse Name_____Spouse Birthdate_____

Spouse Employer_____Occupation_____

Business Address_____Business Phone_____

Who is responsible for this account?_____Relationship to Patient_____

Patient Social Security #_____Spouse Social Security #_____

Name of Dental Insurance Co_____Group #_____

Name of the Insured _____Policy ID#_____

Insurance Address_____Insur Phone #_____
Do you have Additional Dental Insurance? __Yes ___No If yes, Complete the following:

Name of Insured_____Relationship to Patient_____

Birthdate _____ SS# _____Union or Local #_____

Name of Employer _____City _____State_____

Address of Employer_____Phone(___)_____

Insurance Company_____Group #_____Policy #_____

Insurance Co Address_____City _____State_____

In Case of Emergency, who should we notify? _____Phone(__)_____

Who may we thank for referring you? _____

How did you hear about us? _____Newspaper _____Friends/Relatives ____Sign _____Internet

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Dental History

Name of Previous Dentist:_____ Date of Last Exam:_____
Previous Dentist's Location: _____Date of Last Cleaning: _____
Reason for today's visit: _____Date of last dental X-rays:_____
How often do you floss? _____ How often do you brush? _____

Check yes or no to indicate if you have/had the following:

Bad breath:	___yes ___no	Jaw pain or tiredness:	___yes ___no
Bleeding gums:	___yes ___no	Lip or cheek biting:	___yes ___no
Blisters on lips or mouth:	___yes ___no	Loose teeth or broken fillings:	___yes ___no
Burning sensation on tongue:	___yes ___no	Mouth Breathing:	___yes ___no
Chew on one side of mouth:	___yes ___no	Mouth Pain:	___yes ___no
Cigarette, pipe, or cigar smoking:	___yes ___no	Orthodontic treatment:	___yes ___no
Clicking or popping jaw:	___yes ___no	Pain around ear:	___yes ___no
Dry mouth:	___yes ___no	Periodontal treatment:	___yes ___no
Fingernail biting:	___yes ___no	Sensitivity to cold:	___yes ___no
Food collection between teeth:	___yes ___no	Sensitivity to hot:	___yes ___no
Foreign objects in mouth:	___yes ___no	Sensitivity to sweets:	___yes ___no
Grinding teeth:	___yes ___no	Sensitivity when biting:	___yes ___no
Gums swollen or tender:	___yes ___no	Sore or growths in mouth:	___yes ___no

MEDICAL HISTORY

Physician's Name: _____ Date of last visit:_____
Phone: _____ Pharmacy:_____ Phone: _____

Check yes or no to indicate if you have/had the following:

High Blood Pressure:	___yes ___no	Heart Disease:	___yes ___no	Chest Pains:	___yes ___no
Heart Attack :	___yes ___no	Cardiac Pacemaker:	___yes ___no	Easily Winded:	___yes ___no
Rheumatic Fever:	___yes ___no	Stroke:	___yes ___no	MVP:	___yes ___no
Swollen Ankles:	___yes ___no	Heart Murmur:	___yes ___no	Hay Fever/Allergies:	___yes ___no
Fainting/Seizures:	___yes ___no	Angina:	___yes ___no	Tuberculosis:	___yes ___no
Asthma:	___yes ___no	Frequently Tired:	___yes ___no	Radiation:	___yes ___no
Low Blood Pressure:	___yes ___no	Anemia:	___yes ___no	Epilepsy/Convulsions:	___yes ___no
Emphysema:	___yes ___no	Cancer:	___yes ___no	Glaucoma:	___yes ___no
Leukemia:	___yes ___no	Arthritis:	___yes ___no	Recent Weight Loss:	___yes ___no
Diabetes:	___yes ___no	Joint Replacement/Implant:	___yes ___no	Liver Disease:	___yes ___no
Kidney Disease:	___yes ___no	Hepatitis/Jaundice:	___yes ___no	Heart Troubles	___yes ___no
AIDS or HIV infection:	___yes ___no	Sexually Trans. Disease:	___yes ___no	Respiratory Problems:	___yes ___no
Thyroid Problem:	___yes ___no	Stomach Troubles/Ulcers:	___yes ___no	Other, List: _____	

Are you allergic to any of the following?

Aspirin:	___yes ___no	Metals(ex: gold):	___yes ___no	Barbiturates:	___yes ___no
Penicillin:	___yes ___no	Local Anesthesia:	___yes ___no	Sulfa:	___yes ___no
Ibuprofen:	___yes ___no	Iodine:	___yes ___no	Latex:	___yes ___no
Codeine:	___yes ___no	Other, List: _____			

Have you ever taken: Blood thinners: ___yes ___No Coumadin: ___yes ___no
Warfarin: ___yes ___no Levoxyl: ___yes ___no Synthroid: ___yes ___no

Either List all medications or let us copy your list of medications:_____

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FINANCIAL POLICY
DENTAL INSURANCE

OFFICE PHILOSOPHY

Our office remains dedicated to providing optimal care for every patient and working with you to achieve that goal. We pride ourselves on helping you in any way and continuing to provide the quality of care to which you have become accustomed.

ELECTIVE SERVICES

Some services are typically not covered by dental insurance companies. These include, but are not limited to: cosmetic dentistry, implants, occlusion or bite redesign, posterior composites, and other services. Although these are important dental services that can greatly enhance the quality of life for patients, some dental insurance companies do not feel they should have to pay for these services. That is why these services are rarely included in contracts with your employers.

OFFICE POLICY

We have installed a state of the art computer system that includes the ability to obtain ESTIMATED dental benefits based on our office fees. You are expected to pay your estimated portion at the time the services are rendered unless other arrangements have been made in advance.

Please note that our office is a participating provider with several insurance companies, however, we are unable to determine in advance the actual final payment from your dental insurance company. Therefore, your estimated portion is calculated on our office fees. Upon receipt of final payment from the insurance company, in the case of overpayment, your account will be credited, and at your request a refund check will be issued. In the event of an underpayment, we will generate a billing statement for the unpaid balance.

Finally, it is important to remember, services are provided to you and not to your insurance company. You are financially responsible for ALL services provided. If you do not have dental insurance, payment is expected at time of service unless other arrangements have been made.

PATIENT SIGNATURE _____

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Heather Larrimore, D.M.D.
814 Dawn Ave, Ephrata, PA 17522
(717) 733-7971

ACKNOWLEDGEMENT
OF
PRIVACY PRACTICES

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

1. Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers for my health care services.
3. Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my dental provider's "Notice of Privacy Practices" containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such "Notice of Privacy Practices". I understand that my dental provider has the right to change the "Notice of Privacy Practices" and that I may contact this office at the address above to obtain a current copy of the "Notice of Privacy 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 and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Print Name: _____ Date: _____

Signature: _____

Relationship to patient: _____

Dependent family members also covered by this acknowledgement:

_____

_____