EUROPEAN
DENTURE CENTER

Welcome to European Denture Center!
Please carefully fill out your registration information

Date: / /

PATIENT INFORMATION

☐ Male
☐ Female

Full Name:

Birth Date: / / Social Security: – –

Email Address:

Home Ph: ( ) Cell Ph: ( ) Work Ph: ( )

Address:

City: State: Zip:

Your Occupation: Employer:

Spouse's Name: Ph Number: ( )

Treating Dentist's Name:

Name nearest relative not living with you: Ph Number: ( )

Do you wear dentures or partials? If yes, how old are they?

YOUR DENTAL INSURANCE INFORMATION

If you have dental insurance, please fill in all information.

Full Name on Insurance Card:

Birth Date: / / Social Security: – –

Name of Insurance Co: Group No:

Employer: City:

HEALTH RELATED QUESTIONS

Please check "Yes" or "No" to any statements that may apply to you.

	Yes	No
Pain in region of ears	☐	☐
Hepatitis	☐	☐
Coumadin/Warfarin Therapy	☐	☐
Regular Coffee Drinker	☐	☐
Heart Problems	☐	☐
High Blood Pressure	☐	☐
Circulatory Problems	☐	☐
Heart Surgery	☐	☐
Artificial Joints	☐	☐
Regular Alcohol Drinker	☐	☐
Excessive Bleeding	☐	☐
Malignancies	☐	☐
Diabetes	☐	☐
Venereal Disease	☐	☐
AIDS	☐	☐
Smoke/Chew Tobacco	☐	☐

Please list any allergies:

Please describe any current medical treatment, impending operations, pregnancy, or other information that must be taken into consideration:

Referred By:

☐ Friend ☐ Magazine
☐ Yellow Pages ☐ Doctor
☐ Newspaper ☐ Other

EUROPEAN
DENTURE CENTER

AUTHORIZATIONS

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need.

First payment is due at the time your impression is taken, and payment in full is required at the completion of services. **Lab relines are NOT included into the price of the denture. For any returned checks you will be charged $20.00.**

_____ ___/___/___

Patient Signature: Date:

PATIENTS WITH INSURANCE

I certify that I am covered by my Insurance Company and I assign directly to European Denture Center all insurance benefits, otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits.
I authorize the use of this signature on all my insurance submissions.

_____ ___/___/___

Patient Signature: Date:

NOTICE OF PRIVACY PRACTICES (HIPPA Requirements)

The Practice: *(Effective date: This notice is in effect as of 10/01/08.)*

- **A.** Is required by federal law to maintain the privacy of your PHI (Protected Health Information) and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.
- **B.** Under the Privacy Rule, the Practice may be required by State Law to grant access to maintain greater restrictions on the use or release of our PHI than that which is provided for under federal law.
- **C.** Is required to abide by the terms of this Privacy Notice.
- **D.** Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice
- **E.** provisions effective for your entire PHI that it maintains.
- **F.** Will distribute any revised Privacy Notice to you prior to implementation.
- **G.** Will not retaliate you for filing a complaint.

PATIENT ACKNOWLEDGEMENT

By initialing below, I acknowledge receipt of a copy of this notice and my understanding and my agreement to its terms.

_____ ___/___/2020

Patient Initials: Date: