Kelley L. Borders D.M.D.

Patient registration

Information will be held in the strictest of confidence.

Patient Name	**Date**
Address	**S.S.**
City, State, Zip	**D.O.B.** **Age**
Male __ Female __ Single __ Married __ Minor __ Widow __	**Home Phone**
Employer/School	**Work Phone**
Address	**Cell Phone**
City, State, Zip	**E-mail**
Occupation	**Notes:**
Referred by:	

Person responsible for account: Relation:

Your Spouse	**Dental Insurance**
Name	**Policy Holder**
D.O.B.	**Relation to Patient**
S.S.	**Insurance Co.**
Employer	**Group#** **ID#**
Work Phone	**Phone**
Emergency Contact	**Secondary Insurance**
Name	**Policy Holder**
Relationship	**Insurance Co.**
Phone 1:	**Group#** **ID#**
Phone 2:	**Phone**

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the dentist. I understand that I am financially responsible for any balance. I also authorize Kelley L. Borders D.M.D. or insurance company to release any information required to process my claims.

Patient/Guardian signature Date

KELLEY L. BORDERS, D.M.D.

Medical and Dental History

Name: _____ **DOB:** _____ **Today's Date:** _____

Are you under a physician's care now? Yes No Doctor's Name: _____

Phone: _____

Have you ever been hospitalized? Yes No Reason: _____

Have you had a major operation? Yes No What Type: _____

Have you had a serious head or neck injury? Yes No When: _____

Are you taking any medications, pills, or drugs? Yes No: If yes, please list the medications, pills, or drugs:

Have you ever taken Phen-Fen or Redux? Yes No When: _____

Have you ever taken bisphosphonates? Yes No When: _____
(Fosamax, Boniva, Actonel, Zometa)

Are you on a special diet? Yes No Reason: _____

Do you use tobacco? Yes No Type/Amount: _____

Dental History

Are you happy with your past dental visits? Yes No If no, Why? _____

Do you have any fear of dental work? Yes No Please Circle: Slight Moderate Severe

Do your gums bleed when brushing or flossing? Yes No

Do you feel you have bad breath? Yes No

Would you like your teeth to be whiter? Yes No

Do you have trouble opening or closing your jaw? Yes No Please Circle: Opening Closing

Do you like your smile? Yes No If no, Why: _____

When was your last dental cleaning? _____

Have you ever had a reaction to any dental anesthetic? Yes No If yes, what? _____

Have you ever had braces? Yes No

How did you hear about our office? (Please Circle)

Online Search Website Walk-in/Drive By

Friend / Family: _____ Other: _____

KELLEY L. BORDERS, D.M.D.
Medical and Dental History

Medical History

(Women Only) Are you Pregnant/Trying to get Pregnant? ____ Nursing? ____ Taking oral contraceptives? ____

Circle *if you are* ***Allergic*** *to any of the following:*

Aspirin	Penicillin/Amoxicillin	Codeine	Acrylic
Metal	Latex	Sulfa Drugs	Local Anesthetics

Please List any other Allergies: _____

Do you use controlled substances? What?

Circle *if you have any of the following* ***Medical Concerns****:*

AIDS/HIV positive	Hepatitis A	Hepatitis B or C	Drug Addiction
Herpes/Cold Sores	Diabetes	Excessive Thirst	Swelling of Limbs
Shingles	Recent Weight Loss	Sinus Troubles	Frequent Cough
Breathing Problems	Easily Winded	Asthma	Anemia
Excessive Bleeding	Blood Transfusion	Emphysema	Lung Disease
Thyroid Disease	Parathyroid Disease	Liver Disease	Stomach Disease
Sickle Cell Disease	Alzheimer's Disease	High Blood Pressure	Low Blood Pressure
High Cholesterol	Scarlet Fever	Hypoglycemia	Hemophilia
Renal Dialysis	Anaphylaxis	Epilepsy or Seizures	Angina
Rheumatic Fever	Rheumatism	Tuberculosis	Yellow Jaundice
Kidney Problems	Osteoporosis	Artificial Heart Valve	Mitral Valve Prolapse
Tumor or Growths	Congenital Heart Disorder	Heart Murmur	Heart Pacemaker
Heart Attack/Failure	Irregular Heartbeat	Leukemia	Cancer
Radiation Treatments	Chemotherapy	Fainting Spells/Dizziness	Stroke
Psychiatric Care	Bruise Easily	Glaucoma	Frequent Headaches
Arthritis/Gout	Chest Pains		

Do you have a medical concern not listed? Please explain: _____

Additional comments: _____

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 health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian:

X_____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Kelley L. Borders DMD

* You May Refuse to Sign This Acknowledgment*

I have received a copy of this office's Notice of Privacy Practices.

Print Name:_____

Signature:_____

Date:_____

PLEASE LIST ANYONE WE MAY DISCLOSE YOUR PERSONAL HEALTH INFORMATION

_____ Relationship: _____

_____ Relationship: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

24 HOUR APPOINTMENT CANCELLATION POLICY

Dr. Kelley L. Borders has a 24 hour cancellation/rescheduling policy.

If you miss your appointment, cancel or change your appointment with less than 24 hours' notice, you will be charged $25. This is in place out of respect for our patients. Cancellations with less than 24 hours' notice are difficult to fill. This office is a private practice dental office and not a dental "clinic". By giving last minute notice or no notice at all, you prevent someone else from being able to schedule into that time slot, we have reserved just for you.

By signing below, you acknowledge that you have read and understand the Cancellation Policy for Dr. Kelley L. Borders, as described above.

Thank you for your understanding and cooperation.

_____ _____

Printed Name Signature

_____

Date

Kelley L. Borders D.M.D

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT NAME (LAST, FIRST, MI)	MEDICAL RECORD NUMBER
ADDRESS	
CITY/STATE	DATE OF BIRTH

BY SIGNING THIS FORM, I AUTHORIZE THE FOLLOWING:

THE INFORMATION IS TO BE **DISCLOSED BY:**	AND **PROVIDED TO:**
NAME OF FACILITY **Kelley L. Borders D.M.D**	NAME OF PERSON/ORGANIZATION/FACILITY
ADDRESS **1708 S. Alexander St.**	ADDRESS
CITY/STATE **Plant City, FL 33563**	CITY/STATE
PHONE NUMBER **813-752-5600**	PHONE NUMBER

- **PURPOSES OF DISCLOSURE:** *(Check all that apply)*

Further Medical Care	Attorney / Litigation	School
Personal Use	Insurance	Disability
At the Patient's request	Other: *(specify)*	

- **HEALTH INFORMATION TO BE DISCLOSED:** *(Check all that apply)*

Only information related to (specify): _____

_____

Only the period of events from _____ to _____

Other (X-Rays, Billing, etc.) _____

_____

Entire Record

I, _____, hereby authorize the disclosure of information from my health record, as described above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. I understand that my treatment, payment, enrollment, and eligibility for care are not conditioned upon my providing this authorization except in such cases as may be necessary for claim review and appeal purposes.

I understand that I may revoke this authorization in writing at any time by contacting the Practice at the address listed above, except to the extent that action has already been taken in reliance on this authorization. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or expiration event is stated. (*Specify expiration date :* _____).

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164] and the Privacy Act of 1974 [5 USC 552a].

SIGNATURE OF PATIENT	DATE
SIGNATURE OF LEGAL REPRESENTATIVE (state relationship to patient)	DATE

Email and Text Messaging Program Customer Information Form

We provide our customers the option to participate in our online customer communication system.

Some of the system features allow you the ability to:

- Request Appointments via Email
- Confirm Appointments via Email
- Receive Text Message Appointment Reminders
- Submit Customer Satisfaction Surveys
- Refer Your Friends Online

You may opt-out of your communications at any time by clicking the unsubscribe link found in the footer of each email, or by replying to a text message with 'STOP'. Standard text messaging rates apply.

Please Update Your Contact Information

Name: _____

Address: _____

City: _____

State: _____

Zip: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____ ☐ Opt in to text messages

Email: _____ ☐ Opt in to email

Please sign below to indicate that you agree to allow us to use this information in providing your services.

_____

Signature Date