Patient Registration

Date_____

Patient Name: _____Date of Birth:_____

Home Address: _____City: _____ Zip: _____

Home Ph: _____ Cell Ph: _____ Email: _____

Marital Status: S / M / W / OTHER SSN: _____

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

Employer Name: _____ Employer Phone: _____

Person Financially Responsible for Account

Responsible Party: _____Phone:_____ Date of Birth _____

Relationship to Patient: _____ SSN: _____ Driver's License: _____

Address: _____ City _____Zip:____ _____

Employer Name: _____ Employer Phone: _____

Name of nearest relative not living with you? _____ Phone: _____

Payment is required at the time of service unless other arrangements are made in advance!

Primary Insurance Carrier

Insurance Company Name: _____ Phone: _____

Policy Holder's Name: _____ DOB: _____ SSN: _____

Policy Number: _____ Group Number: _____

Secondary Insurance Carrier

Insurance Company Name: _____ Phone: _____

Policy Holder's Name: _____ DOB: _____ SSN: _____

Phone _____Policy Number: _____ Group Number: _____

I, the undersigned patient authorize the release of all information (including x-rays) necessary to process my dental insurance claim, and further authorize that all insurance payments be made directly to the above named Dentist. I understand that dental insurance claims will be submitted for me in a timely manner and at no charge. In addition, I am aware that any outstanding amounts are my responsibility .

Payment is required at time of service, unless other arrangements are made in advance.

Signature _____ Date _____

HEALTH HISTORY FORM

What is the reason for your visit today? _____

Date of last dental visit? _____ Do you grind or clench your teeth? Yes_____ No _____

How often do you brush your teeth? _____ Floss? _____

Are your teeth sensitive? If yes, please describe. _____

Do your gums bleed or hurt? If yes, please describe. _____

Are you satisfied with the appearance of your smile? If not, why? _____

Pharmacy: _____ Ph: _____Physician: _____ Ph: _____

MEDICAL HISTORY

Indicate which of the following you have had or have at the present. Circle "yes" or "no" to each item.

Heart (surgery, disease or attack) …….. YES NO
High Blood Pressure …….. YES NO
Mitral Valve Prolapse …….. YES NO
Artificial Heart Valve or Pacemaker …… YES NO
Heart Murmur ……... YES NO
Rheumatic Fever …….. YES NO
Arthritis/Rheumatism…….. YES NO
Cortisone Medication…….. YES NO
Swollen Ankles…….. YES NO
Stroke…….. YES NO
Kidney Trouble…….. YES NO
Ulcers…….. YES NO
Thyroid Problems…….. YES NO
Glaucoma…….. YES NO
Emphysema…….. YES NO
Tuberculosis……..YES NO
Fainting or Dizzy Spells……..YES NO
Use of tobacco…….. Yes NO

Asthma…….. YES NO
Allergies or Hives…….. YES NO
Sinus Trouble…….. YES NO
Radiation Therapy…….. YES NO
Chemotherapy…….. YES NO
Tumors…….. . YES NO
Hepatitis A, B or C…….. . YES NO
Venereal Disease…….. . YES NO
H.I.V. Positive…….. YES NO
AIDS…….. YES NO
Hemophilia…….. YES NO
Sickle Cell Disease…….. YES NO
Liver Disease…….. YES NO
Neurological problems……..YES NO
Epilepsy or Seizures…….. YES NO
Diabetes…….. YES NO
Artificial Joints…….. YES NO
Use of recreational Drugs…….. YES NO

Are you taking any medications or drugs? If so, what?_____

_

_____

List any medications you are allergic to: _____

_____Latex_____Other_____

Have you been a patient in the hospital during the last five years? _____Are you in good health now?_____

_____

Women: Are you pregnant? _____ Nursing? _____ Taking Birth Control? _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to contact the respective health care provider who may release such information to you. I will notify the Doctor of any change in health or medication. **I have read and agree to the terms and conditions described herein.**

Signature: _____ Date_____

Authorization for Release of Identifying Health Information

I authorize the release of health information identifying me under the following terms and conditions:

1) Information to be disclosed: Patient information, dental treatment, appointments and account balances or payments.
2) Information may be released to the insurance company, healthcare provider and third-party payers.
3) This authorization shall remain in effect from the date signed below.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and other important matters about your protected health information. The Notice of Privacy Practices is in the waiting area and a copy is available upon request. I understand that the information used or disclosed pursuant to the authorization may be subject to disclosure by the recipient and no longer protected by the HIPAA.

Preferred Telephone Contact

Home: _____
____ Leave only a call back name and number on answering machine or with the person who answers.
____ Leave a detailed message on my answering machine.
____ Do not leave any type of message.

Cell: _____
____ Leave only a call back name and number on answering machine or with the person who answers.
____ Leave a detailed message on my answering machine.
____ Do not leave any type of message.

Work: _____
____ Leave only a call back name and number on answering machine or with the person who answers.
____ Leave a detailed message on my answering machine.
____ Do not leave any type of message.

I _____, have had the full opportunity to read and consider the contents of this consent form and the Notice of Privacy Practices(HIPAA). I understand that by signing this consent form, I am giving my consent for the use and disclosures of my protected health information, to carry out treatment, payment activities and health care operations..

Signature: _____ Date: _____

OFFICE FINANCIAL POLICY

Payment is due at the time services are rendered. For your convenience we accept cash, Visa, MasterCard, Discover, personal check, money order, or registered check.

Insurance benefits are determined by your employer and not your dentist.
Any deductible or estimated co-payment amount will be due at the time of treatment.
Insurance is not a guarantee of payment; insurance companies will not pay for all your costs. Your insurance policy is a contract between you and your insurer. Your insurance and payment are still your responsibility. As a courtesy we will be glad to file your claim for you if you bring 1) your dental insurance card and 2) all required employer information. You will be expected to pay for services rendered if the office is unable to verify your insurance information before treatment. **If payment for services already rendered has not been paid in full within 45 days, either by you or your insurance company, the remaining balance for treatment is transferred to you, and is considered due and collectible.**

We reserve the right to charge and collect fees for broken appointments **– appointments that are cancelled or broken without 24-hours advance notice.** Appointments are reserved exclusively for you. As a health benefit to you, we may offer to move your appointment to an earlier time if openings arise.

Returned Check Fee of **$35** (thirty five dollars) will be added to your account balance and is collectible.

Payment plans and financial arrangements can be obtained for comprehensive dental treatment, prior to commencing treatment.

I have read and understand this financial policy.

_____ _____

SIGNATURE **DATE**

_____

PRINTED NAME