PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

EMERGENCY CONTACT

EMERGENCY #

CELL PHONE

PAGER

SEASONAL ADDRESS

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Premier Dentistry

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

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

Are you under a physician's care now?	○ Yes ○ No	If yes
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes
Are you taking any medications, pills, or drugs?	○ Yes ○ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Are you on a special diet?	○ Yes ○ No	
Do you use tobacco?	○ 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 ☐ Sulfa Drugs ☐ Local Anesthetics

Other?	☐	If yes
Do you use controlled substances?	○ Yes ○ No	If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive ○ Yes ○ No	Cortisone Medicine ○ Yes ○ No	Hemophilia ○ Yes ○ No	Radiation Treatments ○ Yes ○ No
Alzheimer's Disease ○ Yes ○ No	Diabetes ○ Yes ○ No	Hepatitis A ○ Yes ○ No	Recent Weight Loss ○ Yes ○ No
Anaphylaxis ○ Yes ○ No	Drug Addiction ○ Yes ○ No	Hepatitis B or C ○ Yes ○ No	Renal Dialysis ○ Yes ○ No
Anemia ○ Yes ○ No	Easily Winded ○ Yes ○ No	Herpes ○ Yes ○ No	Rheumatic Fever ○ Yes ○ No
Angina ○ Yes ○ No	Emphysema ○ Yes ○ No	High Blood Pressure ○ Yes ○ No	Rheumatism ○ Yes ○ No
Arthritis/Gout ○ Yes ○ No	Epilepsy or Seizures ○ Yes ○ No	High Cholesterol ○ Yes ○ No	Scarlet Fever ○ Yes ○ No
Artificial Heart Valve ○ Yes ○ No	Excessive Bleeding ○ Yes ○ No	Hives or Rash ○ Yes ○ No	Shingles ○ Yes ○ No
Artificial Joint ○ Yes ○ No	Excessive Thirst ○ Yes ○ No	Hypoglycemia ○ Yes ○ No	Sickle Cell Disease ○ Yes ○ No
Asthma ○ Yes ○ No	Fainting Spells/Dizziness ○ Yes ○ No	Irregular Heartbeat ○ Yes ○ No	Sinus Trouble ○ Yes ○ No
Blood Disease ○ Yes ○ No	Frequent Cough ○ Yes ○ No	Kidney Problems ○ Yes ○ No	Spina Bifida ○ Yes ○ No
Blood Transfusion ○ Yes ○ No	Frequent Diarrhea ○ Yes ○ No	Leukemia ○ Yes ○ No	Stomach/Intestinal Disease ○ Yes ○ No
Breathing Problems ○ Yes ○ No	Frequent Headaches ○ Yes ○ No	Liver Disease ○ Yes ○ No	Stroke ○ Yes ○ No
Bruise Easily ○ Yes ○ No	Genital Herpes ○ Yes ○ No	Low Blood Pressure ○ Yes ○ No	Swelling of Limbs ○ Yes ○ No
Cancer ○ Yes ○ No	Glaucoma ○ Yes ○ No	Lung Disease ○ Yes ○ No	Thyroid Disease ○ Yes ○ No
Chemotherapy ○ Yes ○ No	Hay Fever ○ Yes ○ No	Mitral Valve Prolapse ○ Yes ○ No	Tonsillitis ○ Yes ○ No
Chest Pains ○ Yes ○ No	Heart Attack/Failure ○ Yes ○ No	Osteoporosis ○ Yes ○ No	Tuberculosis ○ Yes ○ No
Cold Sores/Fever Blisters ○ Yes ○ No	Heart Murmur ○ Yes ○ No	Pain in Jaw Joints ○ Yes ○ No	Tumors or Growths ○ Yes ○ No
Congenital Heart Disorder ○ Yes ○ No	Heart Pacemaker ○ Yes ○ No	Parathyroid Disease ○ Yes ○ No	Ulcers ○ Yes ○ No
Convulsions ○ Yes ○ No	Heart Trouble/Disease ○ Yes ○ No	Psychiatric Care ○ Yes ○ No	Venereal Disease ○ Yes ○ No
			Yellow Jaundice ○ Yes ○ No

Have you ever had any serious illness not listed ○ Yes ○ No If yes

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 (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:

X_____ Date:_____

PREMIER DENTISTRY

COSMETIC, RESTORATIVE, AND SEDATION DENTISTRY

PAYMENT POLICY

In an effort to keep dental costs down while maintaining a high level of professional care, we have established the following payment policy:

1. **PAYMENT ARRANGEMENTS ARE REQUESTED AT THE TIME OF YOUR VISIT.** We offer the following payment options: Personal check, Credit card (Visa, MasterCard, American Express, Discover), CareCredit, and iCare. There is a **$35.00 charge** for all returned checks.

2. New patients being seen on an emergency basis are required to pay for services at the time of visit.

3. Patients with PPO dental are required to pay their deductible and an estimated percentage of the fees not paid by the insurance company. To help in estimating your costs, a copy of the policy benefits should be brought into our office.

4. As a service to our patients, we will submit claims to your insurance company (provided that it is a PPO).

5. Patients without dental insurance are required to make payment when services are rendered.

6. Any fees not paid by the insurance company within 60 days from the date of service become the responsibility of the patient. All payments are due within 60 days of the billing date.

7. The portion paid at the time services are rendered is only an **ESTIMATE** of what your insurance may not pay. If an overpayment should occur, a check will be issued to the patient.

8. Appointments canceled with less than 24 hours' notice **WILL BE BILLED** accordingly.

9. If it is necessary, individual payment plans may be arranged with the business office **PRIOR** to scheduling appointments.

I HAVE READ AND I UNDERSTAND THE ABOVE POLICY. I AGREE TO COMPLY WITH THE TERMS.

SIGNATURE: _____ DATE:_____

FULL NAME (PLEASE PRINT): _____

PREMIER DENTISTRY

COSMETIC, RESTORATIVE, AND SEDATION DENTISTRY

NOTICE OF PRIVACY PRACTICES AND PATIENT ACKNOWLEDGMENT

To our Valued Patient:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers, and doctors continually undergo training to that they may understand and comply with the government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA), with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity when providing services to our patients.

It is our policy to properly determine the appropriate use of PHI in accordance with governmental rules, laws, and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that will help us prevent any inappropriate use of PHI.

It is our policy to listen to our employees and our patients without any risk of penalization if they feel that an even in any way compromises our policy and integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

NOTICE OF PRIVACY

The Department of Health and Human Services has established a Privacy Rule to help ensure that personal health information is protected for privacy. The Privacy Rule provides the rules that must be followed prior to disclosing health information about the patient that is needed to carry out treatment, payment, or health care operations.

We want you, our patients, to know that we respect the privacy of your personal medical records and will do all that we can to secure and protect your privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum information necessary only to those we feel are in need of your health care information. We want to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. You may request restrictions to parties to whom you do not want PHI released. You will be asked to authorize release of PHI to any party who is not directly connected to your treatment, payment, or health care operations.

If you have any questions, comments, or objections to the privacy policies on this form, please speak with one of our staff.

PREMIER DENTISTRY

COSMETIC, RESTORATIVE, AND SEDATION DENTISTRY

VELSCOPE

Did you know that dental insurance doesn't cover oral cancer?

Nearly 50,000 people in the United States will be newly diagnosed with oral cancer this year, with 132 people diagnosed with oral cancer each day.

Unfortunately, your dental insurance is not liable for cancer treatment.

While smoking, using chewing tobacco, and consuming alcohol have been commonly linked to oral cancers, many cases are now also being linked to exposure to the Human Papillomavirus (HPV). In some cases of oral cancer, there is no identifiable cause.

The best way to prevent oral cancer is to get screened regularly. This office uses the VELscope, a non-invasive oral-cancer screening device. By using VELscope to aid in oral cancer screening, your dentist is able to see suspicious areas that could potentially become cancerous.

The VELscope screening is recommended to be administered twice a year and costs $25.00 per screening. Unfortunately, most insurance plans do not cover this exam. Since the VELscope screening is part of our regular standard of care, please let your hygienist know if you wish to opt out of this exam.

Signature:_____ Date:_____

Name (printed): _____