Patient Registration Form

Patient Name: _____
Last Name First Name Middle Initial

Date: _____ SSN: _____ Date of Birth: _____ Sex: Male____ Female____

Address: _____ City: _____ State: _____ Zip: _____

Home phone #:_____ Work phone #:_____ Mobile #:_____

Marital Status: ___ Single ___ Married ___ Divorced ___ Separated ___ Widowed ___ Partnered ___ Minor

E-Mail Address: _____

Patient Employer / School: _____ Occupation: _____

Responsible Party Information: *(responsible for all payments, refunds, and pertinent account info)*

___ Same as patient ___ Different than patient, please fill out information below

Responsible Party Name: _____ Relationship to Patient: _____

Address: _____ SSN: _____ DOB: _____

Phone #:_____ Email: _____

Insurance Information:

Insurance Company: _____ Subscriber ID #:_____

Subscriber Name: _____ DOB: _____ SSN: _____

Employer: _____ Group #: _____

Dental History:

Reason for Today's Visit: _____ Former Dentist: _____

City/State: _____Date of Last Dental Visit: _____Date of last x-rays: _____

Emergency Contact:

Name: _____Phone#:_____

Permission to Contact: *(regarding my health care status, treatment, and financial account info)*

Name: _____ Phone#:_____

Check "yes" or "no" to indicate the following:

Yes__ No__ Bad Breath
Yes__ No__ Bleeding Gums
Yes__ No__ Clicking or Popping Jaw
Yes__ No__ Periodontal Treatment
Yes__ No__ Sensitivity to Sweets
Yes__No__ Sores or growths in your mouth
Yes__ No__ Clenching or grinding teeth
Yes__ No__ Jaw pain or muscle tenderness
How often do you floss? _____
Do you like your smile? _____

Yes__ No__ Burning Sensation on tongue
Yes__ No__ Orthodontic Treatment
Yes__ No__ Dry Mouth
Yes__ No__ Sensitivity to heat or cold
Yes__ No__ Sensitivity when chewing
Yes__ No__ Food collection between teeth
Yes__ No__ Swollen or tender gums
Yes__ No__ Loose teeth or broken fillings
How often do you brush? _____

Whom May We Thank For Referring You? _____

Agreement to Receive Electronic Communication:

I_____DO AGREE **(Please initial)** I_____ DO NOT AGREE

That Stone Post Family Dental may communicate with me electronically at the email address and/or mobile phone number listed above. I am aware that there is some level of risk that third parties might be able to read unencrypted emails. I further agree that I am responsible for providing the dental practice any updates to my email address and/or mobile phone number.
My most preferred method of communication is:

_____Text Messaging Only **(Please initial)**
_____ Email Only
_____ Both are fine with me

I can withdraw my consent to electronic communication at any time by calling:
Stone Post Family Dental | 913-766-0027| frontoffice@stonepostfamilydental.com

Patient Signature (Parent if Minor):_____ Date: _____

StonePost Family Dental

Financial Policy

This agreement is to inform you of your financial obligation to our practice. We are committed to providing you with the most comprehensive dental care using only the highest quality materials and technology available in the market today. All charges you incur for any treatment that is provided are your responsibility regardless of your insurance coverage. We will always recommend treatment based upon your dental needs, not based on insurance coverage, which can be inadequate with some dental plans. Dental insurance is a benefit used to assist you, not to dictate necessary treatment.

Payment is due at time of service. We accept Cash, Check, Visa, Mastercard, and Discover. Debit cards displaying the Visa, Mastercard logo are also accepted. You may also use your flexible spending account through your employer, as long as they have provided you with a debit card. If we need to make payments over a period of time we have interest free options available upon approved credit.

How would you like to pay for your services? Please check one:

_____Cash _____Check _____Credit/debit card _____Extended Payments (OAC)

If you have dental insurance, we will be happy to file your dental insurance claim as a courtesy to you. However, your estimated portion is just that, an ESTIMATE. If there is any remaining balance after we receive payment from your insurance company, that balance will be due within 15 days of notification. Any unpaid balance after 30 days will be subject to an interest charge of 1.8% monthly (21.6% annually). Failure to pay your account balance will result in your account being turned over to a collection agency. At such time, additional processing fees will be added and this action will adversely affect your credit rating.

Appointment Policy

We value your time and always try to serve you in a timely manner. We request that you extend the same courtesy to us. Should you need to change a scheduled appointment, we **require** being informed at least 24 hours in advance. Due to the large amount of time involved in treatment, other patients who may wish to take advantage of your appointment time require at least 24 hour notice to accommodate their schedule. Failure to notify our office within 24 hours may result in a fee of $35.00 to your account. This fee must be paid before any subsequent appointments will be scheduled. Emergencies will be taken into consideration.**If you are over 15 minutes late for your scheduled appointment it may be necessary to change your appointment. We reserve the right to stop seeing patients who are habitually late or miss appointments.

I understand the financial policy and appointment policy as stated. I understand that I am responsible for my dental cost regardless of any insurance coverage. I agree notify the office within 24 hours to change a scheduled appointment.

Signature _____ Date_____

Patient Health History

Stone Post Family Dental

Medical Conditions

- ☐ None
- ☐ AIDS
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valve(s)
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Blood Thinner
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cold Sores/Fever Blisters
- ☐ Congenital Heart Lesions
- ☐ Contact Lenses
- ☐ Cortisone Treatments
- ☐ Cough, persistent or bloody
- ☐ Diabetes
- ☐ Dementia
- ☐ Diet (Special/Restricted)
- ☐ Dizziness/Fainting
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Excessive Bleeding/Bruising
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Murmurs
- ☐ Heart Problems
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Jaw Popping/Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Pace Maker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Sinus Problems
- ☐ Skin Rash
- ☐ Stomach Problems/ Ulcer
- ☐ Stroke
- ☐ Swollen Feet or Ankles
- ☐ Swollen Neck Glands
- ☐ Thyroid Problems
- ☐ Tobacco Use
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Venereal Disease
- ☐ X-Rays/Cobalt Disease

Other:

Allergies

☐ None

Are you allergic to or have you had any adverse reactions to the following:

Antibiotics	*Other Drugs*	*Other Allergies*
☐ Amoxicillin	☐ Acetaminophen	☐ Latex
☐ Cephalexin	☐ Aspirin	☐ Metals (nickel, mercury, etc.)
☐ Erythromycin	☐ Barbiturates	☐ Nuts
☐ Keflex	☐ Codeine	
☐ Penicillin	☐ Hydrocodone	
	☐ Ibuprofen	
	☐ Iodine	
	☐ Local Anesthetics	
	☐ Sulfa	

Other:

Current Medications

☐ None

Addt'l Info:

Are you currently under medical treatment of any kind? ☐ No ☐ Yes

Are you now or have you ever used a bisphosphonate to treat Osteoporosis? (Actonel, Atelvia, Boniva, Fosamax) ☐ No ☐ Yes

Have you been admitted to a hospital or needed emergency care within the last 2 years? ☐ No ☐ Yes

Do you have any health issues or conditions that need further clarification? ☐ No ☐ Yes

- ☐ Pregnant Due Date:
- ☐ Nursing
- ☐ Taking oral contraception

Signature

Date

StonePost Family Dental

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time 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. I also understand you are not required to agree to my request restriction, but if you do agree then you are bound to abide by such restrictions.

Patient Name_____ Relationship to Patient_____

Signature _____ Date _____

Insurance Authorization Signature on File Form

The following authorizations are included on all dental claims. Because we submit the claims for you, a 'Signature on File' must be kept in your record. Please sign both authorizations.

AUTHORIZATION TO RELEASE INFORMATION: I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry our payment activities in connection with this claim.

X _____ Date _____

Signed (patient, parent or legal guardian if minor)

AUTHORIZATION TO PAY BENEFITS TO NAMED DENTIST: I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____ Date _____

I _____, am aware that the insurance coverage fees presented to me by StonePost Family Dental are only an estimate. All treatment not covered by insurance; I the guarantor will be responsible of the amount unpaid.

X_____ Date _____