Patient Registration Form

Date:________________ SSN:____________________ Date of Birth:_______________ Sex: Male ☐ Female ☐

Patient Name: ____
First Name Last Name Middle Initial

Address:__________________________________ City:____________________ State: _________________ Zip: ___________

Home Number: _______________________ Work Number: _______________________ Cell Number: ____________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated E-Mail:____

☐ Minor ☐ Widowed ☐ Partnered for ____years

Patient Employer/School: _________________________________ Occupation: ____

Insurance Information

Responsible Party: __________________________________ Relationship to Patient:____________________________________

Insurance Co.: ______________________________________ Policy Holder's Name: ____________________________________

Date of Birth: _________________________ SSN:_______________________ Employer: ______________________________

Insurance ID#: __________________________________ Group Number: ____

Secondary Insurance?

Responsible Party: __________________________________ Relationship to Patient:____________________________________

Insurance Co.: ______________________________________ Policy Holder's Name: ____________________________________

Date of Birth: _________________________ SSN:_______________________ Employer: ______________________________

Insurance ID#: __________________________________ Group Number: ____

Dental History:

Reason for Today's Visit: _________________________________ Former Dentist: ______________________________________

City/State: ______________________ Date of Last Dental Visit: ___________________ Date of Last X-Rays: ________________

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

Yes ☐ No ☐ Bad breath
Yes ☐ No ☐ Bleeding Gums
Yes ☐ No ☐ Burning sensation on tongue
Yes ☐ No ☐ Cigarette, pipe or cigar smoking
Yes ☐ No ☐ Clicking or popping jaw
Yes ☐ No ☐ Dry mouth
Yes ☐ No ☐ Food collection between teeth
Yes ☐ No ☐ Grinding teeth
Yes ☐ No ☐ Swollen or tender gums
Yes ☐ No ☐ Jaw pain or tiredness
Yes ☐ No ☐ Loose teeth or broken fillings

Yes ☐ No ☐ Mouth Breathing
Yes ☐ No ☐ Orthodontic treatment
Yes ☐ No ☐ Periodontal treatment
Yes ☐ No ☐ Sensitivity to heat or cold
Yes ☐ No ☐ Sensitivity to sweets
Yes ☐ No ☐ Sensitivity when biting
Yes ☐ No ☐ Sores or growths in your mouth
How often do you floss? __________
How often do you brush?__________
Do you like your smile?___________

Whom May We Thank for Referring You?____

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

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 $50.00 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______________________

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 __________