

PATIENT REGISTRATION

Title: (Mr., Mrs., Ms., Dr.) _____ Date: _____

First Name: _____ M.I.: _____ Last Name: _____ Prefers to be called: _____

Date of Birth: _____ Age: _____ Sex: M F SSN: _____

Marital Status: Married Divorced Legally separated Widowed Single

Address: _____

City: _____ State: _____ Zip: _____

Home phone: () _____ Cell: () _____ Work: () _____

Email Address: _____

Are you employed?: Yes No Full Part time Where: _____

Student status: Yes No Full Part time School Name: _____

Physician: _____ Dentist: _____

Pharmacy: _____

How did you hear about our office? (Circle One) Website Phonebook Sign Other: _____

Family/Friend: Who? _____

Name of Parent or Guardian if patient is a minor: _____

<p><i>Primary Insurance Information</i></p> <p>Insurance Co.: _____</p> <p>Address: _____</p> <p>_____</p> <p>Phone: () _____</p> <p>Coverage: Dental _____ Medical _____</p> <p>Group Number: _____</p> <p>Group/Local Name: _____</p> <p>ID#: _____</p> <p>Employer: _____</p> <p>Address: _____</p> <p>_____</p>	<p><i>Primary Policy Holder Information</i></p> <p><small>(Person that is employed or first person listed on the insurance policy)</small></p> <p>Name: _____</p> <p>Relationship to patient: _____</p> <p>Date of Birth: _____ Sex: M F</p> <p>SSN: _____</p> <p>Address: _____</p> <p>_____</p> <p>Phone: Home: () _____</p> <p>Cell: () _____</p> <p>Work: () _____ Ext: _____</p>
<p><i>Secondary Insurance Information</i></p> <p>Insurance Co.: _____</p> <p>Address: _____</p> <p>_____</p> <p>Phone: () _____</p> <p>Coverage: Dental _____ Medical _____</p> <p>Group Name: _____</p> <p>Group/Local Name: _____</p> <p>ID#: _____</p> <p>Employer: _____</p> <p>Address: _____</p> <p>_____</p>	<p><i>Primary Policy Holder Information</i></p> <p><small>(Person that is employed or first person listed on the insurance policy)</small></p> <p>Name: _____</p> <p>Relationship to patient: _____</p> <p>Date of Birth: _____ Sex: M F</p> <p>SSN: _____</p> <p>Address: _____</p> <p>_____</p> <p>Phone: Home: () _____</p> <p>Cell: () _____</p> <p>Work: () _____ Ext: _____</p>

Reason for today's visit: _____

Are you currently under a physician's care? YES NO
If yes, for what condition(s): _____

Name of my physician(s): _____

GENERAL HEALTH QUESTIONNAIRE

PLEASE CHECK **YES OR NO** FOR EACH OF THE FOLLOWING (PLEASE ANSWER ALL QUESTIONS)

Anemia/Thin Blood	<input type="checkbox"/> YES <input type="checkbox"/> NO	Heart Murmur	<input type="checkbox"/> YES <input type="checkbox"/> NO
Angina/Chest pain	<input type="checkbox"/> YES <input type="checkbox"/> NO	Hepatitis/Liver	<input type="checkbox"/> YES <input type="checkbox"/> NO
Arthritis	<input type="checkbox"/> YES <input type="checkbox"/> NO	High Blood Pressure	<input type="checkbox"/> YES <input type="checkbox"/> NO
Artificial joint replacement	<input type="checkbox"/> YES <input type="checkbox"/> NO	Immune Deficiency	<input type="checkbox"/> YES <input type="checkbox"/> NO
Asthma	<input type="checkbox"/> YES <input type="checkbox"/> NO	Kidney or Dialysis	<input type="checkbox"/> YES <input type="checkbox"/> NO
Bleeding problems	<input type="checkbox"/> YES <input type="checkbox"/> NO	Mitral valve prolapsed	<input type="checkbox"/> YES <input type="checkbox"/> NO
Bronchitis	<input type="checkbox"/> YES <input type="checkbox"/> NO	Osteoporosis	<input type="checkbox"/> YES <input type="checkbox"/> NO
Cancer	<input type="checkbox"/> YES <input type="checkbox"/> NO	Psychiatric therapy	<input type="checkbox"/> YES <input type="checkbox"/> NO
Convulsions/seizures	<input type="checkbox"/> YES <input type="checkbox"/> NO	Rheumatic fever	<input type="checkbox"/> YES <input type="checkbox"/> NO
Cough/Cold presently	<input type="checkbox"/> YES <input type="checkbox"/> NO	Stomach Ulcer	<input type="checkbox"/> YES <input type="checkbox"/> NO
Diabetes	<input type="checkbox"/> YES <input type="checkbox"/> NO	Stroke/Weakness	<input type="checkbox"/> YES <input type="checkbox"/> NO
Emphysema	<input type="checkbox"/> YES <input type="checkbox"/> NO	Thyroid problems	<input type="checkbox"/> YES <input type="checkbox"/> NO
Glaucoma	<input type="checkbox"/> YES <input type="checkbox"/> NO	TMJ problems	<input type="checkbox"/> YES <input type="checkbox"/> NO
Heart Attack	<input type="checkbox"/> YES <input type="checkbox"/> NO	Tuberculosis	<input type="checkbox"/> YES <input type="checkbox"/> NO
Cardiac Stent	<input type="checkbox"/> YES <input type="checkbox"/> NO	Gastric Reflux	<input type="checkbox"/> YES <input type="checkbox"/> NO
Radiation Therapy (Head/Neck)	<input type="checkbox"/> YES <input type="checkbox"/> NO	Sleep Apnea	<input type="checkbox"/> YES <input type="checkbox"/> NO

Any other medical problems not listed above: _____

Are you now using or have you ever used drugs such as:

Cocaine, Heroin, Methamphetamine, Marijuana or Others? YES NO

Are you a Smoker? YES NO If Yes, How many a day? _____

Are you a Drinker? YES NO If Yes, How often? _____

Personal/Family history of unusual reactions or complications to anesthesia or surgery? YES NO

If YES, describe: _____

Medication allergies:

Aspirin YES NO

Codeine YES NO

Iodine YES NO

Penicillin YES NO

Other: _____

Other Allergies:

Sulfite preservatives YES NO

Latex YES NO

Soy YES NO

Sulfa YES NO

WOMEN: On birth control pills? YES NO (Antibiotics may interfere with these medications)

Currently nursing? YES NO

Do you think you may be pregnant? YES NO Date of your last menstrual cycle: _____

Do you wish to consult your physician to rule out pregnancy before surgery? YES NO

Recent cortisone/steroid therapy? YES NO

Please list previous surgeries and/or hospitalizations: _____

Please list all medications, pills, herbal medicines: _____

Would you like to discuss any other issues with the Doctor? Yes No

I certify that the above information is correct to the best of my knowledge:

Signature: _____ **Date:** _____

PARENT OR GUARDIAN IF PATIENT IS A MINOR

PATIENT DISCLOSURE INSTRUCTIONS

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (*check all that apply*):

- | | |
|--|--|
| <input type="checkbox"/> Home Telephone _____ | <input type="checkbox"/> Written Communication |
| <input type="checkbox"/> O.K. to leave message with detailed information | <input type="checkbox"/> O.K. to mail to my home address |
| <input type="checkbox"/> Leave message with call-back number only | <input type="checkbox"/> O.K. to mail to my work address |
| | <input type="checkbox"/> O.K. to fax to number indicated |
| <input type="checkbox"/> Work Telephone _____ | <input type="checkbox"/> Other (Fax/Cell, etc.) _____ |
| <input type="checkbox"/> O.K. to leave message with detailed information | |
| <input type="checkbox"/> Leave message with call-back number only | |

I allow you to give my clinical information to or answer questions from (*check all that apply*):

- Spouse
- Parent
- Child
- Other (specify): _____
- None

EMERGENCY CONTACT:

NAME: _____ RELATIONSHIP: _____

PHONE NUMBER: _____

Patient Signature

Date

Print Name

Birth date

Financial Policy Guidelines

You are entitled to a clear understanding of your financial obligations before treatment is rendered. A wide variety of services are available in this office, therefore, we do not have a uniform policy that covers all procedures and treatments.

PAYMENT IN FULL IS EXPECTED AT THE TIME SERVICE IS RENDERED. For your convenience, we do accept Visa, MasterCard, Discover, and American Express. We also offer Care Credit financing for qualified patients. **If time allows**, we will check your insurance benefits at time of 1st visit. On subsequent visits, for procedures that are a covered expense under your insurance contract, you will be required to pay the portion not covered by insurance. We do not determine the amount of coverage you receive from your insurance company. If your insurance company has not paid the balance of your account **within 45 days from the date of service**, you will have **15 days** to pay the balance. If your insurance company pays more than the balance due, we will send a refund check to you. You are responsible for any balance left after your insurance company has paid their portion. After completion of service, we will file your insurance for you and we will assist you in trying to receive maximum benefits.

If you want a **pre-determination of benefits**, please make this request at the time of your consultation as this takes time to receive.

Insurance is a contract between **you and your insurance company**. This office is NOT a part of this contract. We will file insurance claims as a courtesy to our patients. We will not become involved in disputes between you and your insurance company regarding what the insurance considers as their “usual and customary charges”, deductibles, co-payments, covered charges, or secondary insurance, other than to supply factual information as necessary to the insurance company. **You are ultimately responsible for the timely payment of your account.**

PLEASE BE READY TO PAY FOR TREATMENT WHEN RENDERED. You will be provided with an estimate of fees before the beginning of treatment. If you are unable to pay your portion of payment, we will schedule your treatment at another time.

Patients who schedule and then “break” their surgical appointment (without notifying the office at least 24 hours in advance of the scheduled appointment) will be charged a fee of \$100.00. Therefore, please be kind enough to call us if you will not be able to keep your appointment.

By my signature, I have read, or have had this form read to me, and I understand the financial guidelines of the office.

SIGNATURE _____ DATE _____