Patient Registration

First Name: ____________________________ **Last Name**: ________________________ **Middle Initial:** _____

Preferred Name: _______________________ **Referred By:** ____

PATIENT INFORMATION

Address: ____

Address 2: ____

City: ____________________________________ **State/Zip:** ___________________________

Home Phone: ___________________________________

Sex: ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: ________________________ **Age:** ___________ **Soc Sec:** _____________________

Email: ____

RESPONSIBLE PARTY **(if someone other than the patient)**

First Name: ____________________________ **Last Name**: ________________________ **Middle Initial:** _____

Address: ____

Address 2: ____

City: ____________________________________ **State/Zip:** ___________________________

Home Phone: _________________________________ **Work Phone:** _________________________________

Birth Date: ____________________ **Soc Sec:** ___________________ **Drivers Lic:** _______________________

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

Emergency Contact: ___________________________ **Emergency Phone:** ____________________________

Patient/Parent or Guardian Signature: ____________________________________ **Date:** _______________

Patient Questionere

Patient Name: ____

We would like to extend a very warm welcome to you! We sincerely appreciate you choosing us for your dental care and we look forward to getting to know you. If there is anything we can ever do to improve your experiences with us, please don't hesitate to ask.

Please fill out the following questions so that we may make your appointment as comfortable as possible.

When was your last Dental Visit?

- ☐ 0-6 Months ago
- ☐ 6-12 Months ago
- ☐ 12-24 Months ago
- ☐ More than 2 years ago
- ☐ More than 5 years ago

How did you hear about our office? ___________________________

Are you happy with your smile?

- ☐ I would like straighter teeth
- ☐ I would like whiter teeth
- ☐ I am happy with my smile

Do you have any of the following? (Please Circle)

Pain in Jaw TMJ	Teeth Grinding/Clenching	Sensitive Teeth
Broken/Loose Teeth	Difficulty Chewing/Swallowing	Swollen Gums/Bleeding
Gag Reflex		

Do you require any reasonable accommodations for your appointment? (i.e.; cannot move to dental chair from wheel chair, cannot lay back all of the way, cannot move head/neck, pillow etc.)

____

Have you ever been told you require an Antibiotic (pre-medication) prior to Dental Appointments?

- ☐ Yes
- ☐ No

Have you ever had a reaction to anesthetic?

- ☐ Yes
- ☐ No

Do you have a fear of the dental office?

- ☐ Yes
- ☐ No

Do you request Oral Conscious Sedation or Nitrous? (check all that apply) additional fees do apply. (please check all that apply)

- ☐ Nitrous Oxide for Hygiene Appointments
- ☐ Nitrous Oxide for Restorative Appointments
- ☐ Oral Conscious Sedation
- ☐ Sedative (Valium)
- ☐ I want more information
- ☐ I am not interested in Sedation Options

Do you wear any of the following appliances? (Please bring them to ALL of your appointments)

- ☐ Occlusal Guard (Night Guard)
- ☐ TMJ Device
- ☐ Retainer(s)
- ☐ Denture(s)
- ☐ Partial(s)

Signature of Patient ____

Medical History

____________________________ ______________

Patient Name Patient Birth Date

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 that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

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 ____

Do you use controlled substances? ☐ 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 have, or have you had, any of the following?

- ☐ AIDS/HIV Positive
- ☐ Alzheimer's Disease
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ Breathing Problems
- ☐ Bruise Easily
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Cold Sores/Fever Blisters
- ☐ Convulsions
- ☐ Congenital Heart Disorder
- ☐ Cortisone Medicine
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Easily Winded
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Fainting Spell/Dizziness
- ☐ Frequent Cough
- ☐ Genital Herpes
- ☐ Frequent Diarrhea
- ☐ Frequent Headaches
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack/Failure
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Heart Trouble/Disease
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hives or Rash
- ☐ Hypoglycemia
- ☐ Irregular Heartbeat
- ☐ Leukemia
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Pain in Jaw Joints
- ☐ Parathyroid Disease
- ☐ Psychiatric Care
- ☐ Radiation Treatments
- ☐ Recent Weight Loss
- ☐ Renal Dialysis
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Spina Bifida
- ☐ Stomach/Intestinal Disease
- ☐ Stroke
- ☐ Swelling of Limbs
- ☐ Thyroid Disease
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors or Growths
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Yellow Jaundice

Have you ever had any serious illnesses not listed above? ☐ 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.

____ _________________________

Patient/Parent or Guardian Signature Date

Insurance Information

Primary Insurance

Name of Insured: ____

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

Insured Soc. Security: ______________________________ Insured Birth Date: ________________

Employer: ____

Secondary Insurance

Name of Insured: ____

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

Insured Soc. Security: ______________________________ Insured Birth Date: ________________

Employer: ____

Records Release

Release of Information for: ____

I hereby authorize my previous dental office to release my dental records to Summit Family & Cosmetic Dentistry.

Please forward the following information:

FMX and/or Pano X-Rays
Bitewing X-Rays
Date of Last Dental Cleaning
If patient has history of SRP or Perio Maintenance

This information is necessary for providing the dentist information to continue my dental treatment.

This information can be e-mailed to: patients@alopezdds.com

Previous Dental Office Name: ____

Previous Dental Office Location: ____

Patient Name (Please Print) ____

Signature____ Date _________________________

Notice of Privacy Practices & Privacy Authorization

Patient Name: ____

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

- Provide and coordinate my treatment among a number of health care providers who may be involved in my treatment directly or indirectly.
- Obtain payment from third-party payers for my health care services.
- Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office 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 and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound by such restrictions.

Signature ____ Date __________________________

Many of our patients allow family members or others disclose to them to call and request information regarding their condition and/or treatment. Under requirements of HIPPA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your dental condition and/or dental treatment disclosed to someone else, please indicate below. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Name of Person who may receive private information from my account:

____

Relationship to Patient: ____

Signature ____ Date __________________________

Financial Policy

Patient Name: ____

Policy

Our primary goal is not to allow the cost of treatment to prevent you from benefiting from the quality of care you need or desire. In our office, we strive to maximize your insurance benefits and make any remaining balance easily affordable.

Our fees are based on the quality of materials we use, our time, and our effort and skill required to perform your needed treatment. We charge what is usual and customary for our area. We will assist you with your benefit eligibility before treatment to help you calculate your costs and maximize your insurance. We will be sensitive to your financial circumstances and do everything possible to help you achieve oral health.

We accept

- Cash
- Credit Cards
- Checks
- Care Credit

Insurance

Your insurance policy is an agreement between you and the insurance company; we ask that all patients are directly responsible for all charges. Your **estimated** co-payment will be due at the time of service. We are happy to submit the claims necessary to help you receive the full benefits of your coverage; however, you are ultimately responsible for the total balance. Please know that we will do everything possible to see that you receive the full benefits of your policy by electronically filing your claim the day of your appointment. If there are any complications, we will assist you with any information you may need.

All or part of this financial arrangement may be a private contract. Only treatment submitting through an insurance carrier is subject to filed fees. This agreement is being executed under authority of RCW 48.43.085 as a responsibility for any services delivered outside the health care plan. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

When services are submitted to insurance, they are bound by the insurance filed fees. <u>We cannot offer any discounts or write-off's if services have been submitted to your insurance.</u> Once services have been submitted to insurance, they will determine your out-of-pocket cost and you will be responsible for this amount.

Returned Checks

A returned check fee of $30.00 will be added to your account for any returned check.

Collections

All Past Due Balances referred to a Collection Agency will have a 35% collection fee added to their balance. We make every attempt to refrain from submitting to collections. Please contact our office if you are having trouble making your payments to see if we can make arrangements.

Missed/Cancelled Appointments

At Summit Family & Cosmetic Dentistry, we put our faith in you to keep your appointment. When we set up an appointment, a specific amount of time is reserved especially for you. When a patient doesn't not show up for an appointment or cancels too close to their scheduled time, we are unable to fill that appointment time with another patient who needs dental care. This policy is our attempt to ensure that both you and our other patients receive the dental care that you need.

Broken Appointments - Patients are allowed ONE broken appointment in a 12-month period, after which charges will apply.

> **No Show -** If you schedule an appointment and do not call to cancel and do not show up for your scheduled time, this is considered a broken appointment.
>
> **Late Cancellations -** We require 48 hours notice prior to your appointment time to cancel. If you cancel within 48 hours of your appointment, it will be considered a broken appointment.
>
> **Late Arrival -** Late arrivals are also considered broken appointments if you do not arrive within 10 minutes after the start time of your appointment.
>
> **Pre-Medication -** If you require pre-medication (antibiotic) prior to dental treatment and you do not take your medication, this will be considered a broken appointment. We cannot treat you if this is recommended by your physician.

As a courtesy, we send our hygiene reminder post cards, e-mail reminders, and/or provide a phone call or text message prior to your appointment. **Again, these reminders are a courtesy.** If for some reason you do not receive these reminders, your appointment is still your responsibility and **charges will still apply if the appointment is not kept or cancelled properly.**

Broken Appointments will incur a $25.00 charge for Hygiene Appointments and $50.00 charge for Restorative appointments. These fees will be charged per family member if multiple appointments scheduled are broken.

Please Note: Insurance DOES NOT pay for this charge. In addition, we also reserve the right to dismiss you from our practice.

Signature ____ Date ___________________________