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

Referred By

Previous Dentist

Emergency Contact

Emergency Contact #

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:

Wooster Dental Care PC

Eaglesoft Medical History(Copy)(Copy)(Copy)

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 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 for a specific medical problem?	○ Yes ○ No	If yes	
Have you ever been hospitalized or had an 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? Please write or provide list.	○ Yes ○ No	If yes	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes	
Do you use tobacco?	○ Yes ○ No		
Do you take any blood thinners to include aspirin?	○ Yes ○ No	If yes	
When was your last dental cleaning and x-rays?		Comment	
How often do you have your teeth cleaned?		Comment	

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

☐ Clindamycin

Are you allergic to any other medications not listed? ○ Yes ○ No If yes

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

AIDS/HIV Positive ○ Yes ○ No	Hemophilia ○ Yes ○ No	Radiation Treatments ○ Yes ○ No	Diabetes ○ Yes ○ No
Hepatitis A ○ Yes ○ No	Recent Weight Loss ○ Yes ○ No	Drug Addiction ○ Yes ○ No	Hepatitis ○ Yes ○ No
Anemia ○ Yes ○ No	Easily Winded ○ Yes ○ No	Rheumatic Fever ○ Yes ○ No	Angina ○ Yes ○ No
Emphysema ○ Yes ○ No	High Blood Pressure ○ Yes ○ No	Arthritis/Gout ○ Yes ○ No	Epilepsy or Seizures ○ Yes ○ No
High Cholesterol ○ Yes ○ No	Artificial Heart Valve ○ Yes ○ No	Excessive Bleeding ○ Yes ○ No	Hives or Rash ○ Yes ○ No
Artificial Joint ○ Yes ○ No	Hypoglycemia ○ Yes ○ No	Asthma ○ Yes ○ No	Fainting Spells/Dizziness ○ Yes ○ No
Irregular Heartbeat ○ Yes ○ No	Sinus Trouble ○ Yes ○ No	Blood Disease ○ Yes ○ No	Kidney Problems ○ Yes ○ No
Leukemia ○ Yes ○ No	Stomach/Intestinal Disease ○ Yes ○ No	Breathing Problems ○ Yes ○ No	Liver Disease ○ Yes ○ No
Stroke ○ Yes ○ No	Bruise Easily ○ Yes ○ No	Low Blood Pressure ○ Yes ○ No	Cancer ○ Yes ○ No
Lung Disease ○ Yes ○ No	Thyroid Disease ○ Yes ○ No	Chemotherapy ○ Yes ○ No	Hay Fever ○ Yes ○ No
Mitral Valve Prolapse ○ Yes ○ No	Chest Pains ○ Yes ○ No	Heart Attack/Failure ○ Yes ○ No	Osteoporosis ○ Yes ○ No
Tuberculosis ○ 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	Ulcers ○ Yes ○ No	Convulsions ○ Yes ○ No
Heart Trouble/Disease ○ Yes ○ No	Psychiatric Care ○ Yes ○ No	Venereal Disease ○ Yes ○ No	Yellow Jaundice ○ Yes ○ No
Sleep Apnea ○ Yes ○ No	Snoring ○ Yes ○ No		

Have you ever had any serious illness 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.

Signature of Patient, Parent or Guardian:

X Date:_____

Wooster Dental Care Financial Policy

We are dedicated to providing the highest quality dental care and service possible. Please understand that our financial policies are an important part of your care and treatment. To deliver the best possible care for the lowest fee, we find it necessary to implement the following policies. If you have any questions, please do not hesitate to discuss them with our dental team.

Broken or Failed/Missed Appointments: We reserve the right to charge 45.00 for any broken or failed appointments without 24 hour notice. We do understand that emergencies happen, such as a sickness for you or a family member and the fee is waived for certain circumstances. Three (3) missed appointments will result in dismissal from the practice.

Payment is due at the time of services are rendered. For you convenience we accept cash, check (a photo driver's license must be on file) money order. Credit cards also accepted are: Amex, Visa, MasterCard and Discover. We also accept Care Credit.

Insurance: Insurance will be filed for you, as long as deductibles and estimated portions are paid at the time of treatment. Please understand that your insurance is a contract between you and your insurance carrier and that you are ultimately responsible for your services. WE DO NOT PARTICPATE IN ANY PPO NETWORKS OR ARE CONTRACTED WITH ANY INSURANCE COMPANIES. Any amounts not paid by insurance are your responsibility. We will gladly help you receive your maximum allowable benefits and, as a courtesy we will file insurance claims for services rendered. Please be aware that insurance carriers do not cover 100% of dental healthcare cost. Some pay on percentages and others on fee schedules. Please familiarize yourself with your insurance benefits. IF YOU'RE INSURANCE CARRIER FAILS TO PAY ITS ESTIMATED PORTION OF YOUR CHARGES WITHING THE 45 DAYS, OR IF THERE IS A REMAINING BALANCE AFTER THE INSURANCE PAYMENT, THEN THAT AMOUNT BECOMES YOUR RESPONCILBILITY. We will file your insurance as long as you remain current with your cleanings every year.

Return checks: You must take care of a RETURN CHECK within 7 days or it will automatically be handled by the local magistrate's BAD Check Program. Any fees associated with this check will be paid by you.

Past Due Accounts: If your account is not paid within 90 days, unless payment arrangements were made in advance, it will be turned over to legal collections. You will not be extended credit for future services as that trust relationship has been broken with account 90 days past due. You will be responsible for any collections fees involved in collecting this debt.

We appreciate the opportunity to serve you so please let us know if we can do anything to make your experience in our office more enjoyable. Do not hesitate to ask any questions you may have about treatment or our financial policy.

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY OF WOOSTER DENTAL CARE AND AGREE TO BE BOUND BY ITS TERMS AND CONDITIONS.

PATIENT PRINT NAME: _____PATIENT SIGNATURE_____

DATE: _____

HIPAA POLICY : Wooster Dental Care

THIS NOTICE DESCRIBES TO WHOM MEDICAL INFORMATION ABOUT YOU MAY BE DISCOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE READ AND REVIEW CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides privacy protections to your medical records. Our benefits office sometimes needs to disclose medical information or payment information protected by HIPAA in relation to our group health plans to family members or close friends involved in your health care. For example, your spouse may need to contact us if you are in the hospital to determine whether a particular procedure is covered under your insurance coverage, or may want to discuss treatment you need and cost involved. Under HIPAA, unless you specifically object we are allowed to use our professional judgment in deciding whether to discuss your medical and payment information with your family members or close friends. With insurance companies we sometimes need to answer questions when they are processing your claims. However, we would like to provide you with the opportunity to tell us with whom we may discuss your medical or payment information with.

You may communicate with the following individuals relating to my medical or payment information.

_____ _____

_____ _____

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Service, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person our address or email. If you prefer, you can discuss your complaint in person or by phone.

ACKNOWLEDGEMENT OF RECEIPT OF THE HIPPA CONSENT FORM

I acknowledge that I received a copy of the HIPAA consent form.

_____ _____

Patient Signature **Date**