WINDY HILL DENTISTRY

Patient Registration

Today's Date: _____

First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name: _____

Date of birth: _____ Age: _____ Sex: ☐ M ☐ F

Address: _____

City: _____ State: _____ Zip code: _____

Home phone number: _____ Cell phone number: _____

Email address: _____

Social Security Number: _____

I preferred to be contacted by (circle one): ○ Email ○ Text ◉ Phone Call

The best time to contact me is: _____

How did you hear about our office: _____

Employer: _____ How long there: _____

Address: _____

Position: _____ Work Phone: _____

Do you have dental insurance? ☐ Yes ☐ No Insurance Co. Name: _____

So that we can assist you with filing your claim, please provide us with your dental insurance card and form.

If above patient is a minor please complete the following:

Name of parent or legal guardian: _____

Relationship: _____ Birthday: _____

Home number: _____ Cellphone number: _____ Work number: _____

Social security number: _____

Address: _____ Apt. #: _____

City: _____ State: _____ Zip code: _____

Employer: _____ How long there: _____

Position: _____

Address: _____

In case of emergency, please contact: _____ Relation: _____

Phone number: _____ Other number: _____

Payment, Financial, and Insurance Information

We appreciate the opportunity to serve you. It I our intention to provide you with the finest care possible, while ensuring that you fully understand procedures, treatment, and payment expectations.

We ask that all payments or co-payments be made at the time of service. For your convenience, we accept check, cash, Visa, Mastercard, Discover, Amex, and Care Credit.

Insurance: Our office is happy to help you process your insurance. We will complete our portion of the claim form and mail it promptly at no charge. To avoid confusion, it should be understood that insurance billing is an elective service provided to our patients. Difficulty obtaining insurance payments may occur, and **insurance payments cannot be guaranteed. Patient is solely and ultimately responsible for payment.**

If you have questions, we would appreciate your prompt inquiry.

I have read and understand the above information: _____ (Please initial)

Scheduling Information

Except in emergency situations, you can expect us to be on time for you, and we will appreciate the same courtesy.

Your appointment time is tailored for you. **If the need arises to reschedule your appointment, please provide at least 2 days notice.**

Without adequate notification, we will not be able to give you reserved time to another patient in need of dental care. **There is a $25.00 broken appointment fee for every schedule appointment not kept.** This fee covers the room preparation charge and the idle time of the Doctor, hygienist, and dental assistant who were on duty to provide your personalized care.

If your schedule does not permit you to plan in advance, we might suggest placing you on our list of patients to call on a short notice basis.

If you have any questions, we would appreciate your prompt inquiry.

I have read and understand the above information: _____ (Please initial)

Notice of Privacy Practices - Acknowledgement

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your records to others unless you direct us to do so, or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our Office Manager, Christine O' Neill.

Our Notice of Price Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

_____ Date: _____

Patient or legally authorized individual signature

_____ _____ _____

Printed name if signed on behalf of patient | Relation | Patient name

MEDICAL HISTORY

PATIENT NAME: _____ **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, please explain: _____
Have you ever been hospitalized or had a major operation?	○ Yes	◉ No	If yes, please explain: _____
Have you ever had a serious head or neck injury?	○ Yes	◉ No	If yes, please explain: _____
Are you taking any medications, pills, or drugs?	○ Yes	◉ No	If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes	◉ No	_____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes	◉ No	_____
Are you on a special diet?	○ Yes	◉ No	
Do you use tobacco?	○ Yes	◉ No	
Do you use controlled substances?	○ Yes	◉ No	

Women: Are you

Pregnant/Trying to get pregnant? ○ Yes ○ No Taking oral contraceptives? ○ Yes ○ No Nursing? ○ Yes ○ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

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

AIDS/HIV Positive ○ Yes ◉ No	Cortisone Medicine ○ Yes ◉ No	Hemophilia ○ Yes ◉ No	Radiation Treatments ○ Yes ◉ No
Alzheimer's Disease ○ Yes ◉ No	Diabetes ○ Yes ◉ No	Hepatitis A ○ Yes ◉ No	Recent Weight Loss ○ Yes ◉ No
Anaphylaxis ○ Yes ◉ No	Drug Addiction ○ Yes ◉ No	Hepatitis B or C ○ Yes ◉ No	Renal Dialysis ○ Yes ◉ No
Anemia ○ Yes ◉ No	Easily Winded ○ Yes ◉ No	Herpes ○ Yes ◉ No	Rheumatic Fever ○ Yes ◉ No
Angina ○ Yes ◉ No	Emphysema ○ Yes ◉ No	High Blood Pressure ○ Yes ◉ No	Rheumatism ○ Yes ◉ No
Arthritis/Gout ○ Yes ◉ No	Epilepsy or Seizures ○ Yes ◉ No	High Cholesterol ○ Yes ◉ No	Scarlet Fever ○ Yes ◉ No
Artificial Heart Valve ○ Yes ◉ No	Excessive Bleeding ○ Yes ◉ No	Hives or Rash ○ Yes ◉ No	Shingles ○ Yes ◉ No
Artificial Joint ○ Yes ◉ No	Excessive Thirst ○ Yes ◉ No	Hypoglycemia ○ Yes ◉ No	Sickle Cell Disease ○ Yes ◉ No
Asthma ○ Yes ◉ No	Fainting Spells/Dizziness ○ Yes ◉ No	Irregular Heartbeat ○ Yes ◉ No	Sinus Trouble ○ Yes ◉ No
Blood Disease ○ Yes ◉ No	Frequent Cough ○ Yes ◉ No	Kidney Problems ○ Yes ◉ No	Spina Bifida ○ Yes ◉ No
Blood Transfusion ○ Yes ◉ No	Frequent Diarrhea ○ Yes ◉ No	Leukemia ○ Yes ◉ No	Stomach/Intestinal Disease ○ Yes ◉ No
Breathing Problem ○ Yes ◉ No	Frequent Headaches ○ Yes ◉ No	Liver Disease ○ Yes ◉ No	Stroke ○ Yes ◉ No
Bruise Easily ○ Yes ◉ No	Genital Herpes ○ Yes ◉ No	Low Blood Pressure ○ Yes ◉ No	Swelling of Limbs ○ Yes ◉ No
Cancer ○ Yes ◉ No	Glaucoma ○ Yes ◉ No	Lung Disease ○ Yes ◉ No	Thyroid Disease ○ Yes ◉ No
Chemotherapy ○ Yes ◉ No	Hay Fever ○ Yes ◉ No	Mitral Valve Prolapse ○ Yes ◉ No	Tonsillitis ○ Yes ◉ No
Chest Pains ○ Yes ◉ No	Heart Attack/Failure ○ Yes ◉ No	Osteoporosis ○ Yes ◉ No	Tuberculosis ○ Yes ◉ No
Cold Sores/Fever Blisters ○ 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	Parathyroid Disease ○ 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

Have you ever had any serious illness not listed above? ○ Yes ◉ No

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: _____ DATE: _____

INSURANCE FILING POLICY

Our office will file your insurance as a courtesy to you. Any co-payments or money owed for services is due on the day of your appointment. Please understand that we are giving an ESTIMATE of what the insurance may pay for the services you are receiving. We are also giving an ESTIMATE of what your out-of-pocket expense is. When we receive a payment from the insurance company, the amount of the payment may be different than what was ESTIMATED. If this leaves a balance on your account, you will be sent a statement with the balance that is due. The balance is YOUR responsibility and payment will be due promptly. If there is a case where you have over-paid on your account, that money will be refunded to you or you may leave the credit on your account for future services.

I acknowledge that I have read the above policy and understand it fully.

_____ _____

Patient Signature Date