

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.

<p>Section 2</p> <p>Employment Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired</p> <p>Student Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time</p> <p>Medicaid ID: _____ Pref. Dentist: _____</p> <p>Employer ID: _____ Pref. Pharmacy: _____</p> <p>Carrier ID: _____ Pref. Hyg: _____</p>	<p>Section 3</p> <p>emergency contact _____</p> <p>emergency phone # _____</p> <p>Credit Card _____</p> <p>Who Referred You: _____</p>
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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: _____

Eaglesoft Medical History(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, c

Are you under a physician's care now? Have you ever been hospitalized or had a major operation? Have you ever had a serious head or neck injury? Are you taking any medications, pills, or drugs? Do you take, or have you taken, Phen-Fen or Redux? Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Are you on a special diet? Do you use tobacco? Do you use controlled substances? Do you need to Pre-Medicare Before a Dental Visit?

Women: Are you...

Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin Metal Penicillin Latex Codeine Sulfa Drugs Acrylic 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 Breathing Problems Bruise Easily Cancer Chemotherapy Chest Pains Cold Sores/Fever Blisters Congenital Heart Disorder Convulsions Yellow Jaundice Cortisone Medicine Diabetes Drug Addiction Easily Winded Emphysema Epilepsy or Seizures Excessive Bleeding Excessive Thirst Fainting Spells/Dizziness Frequent Cough Frequent Diarrhea Frequent Headaches Genital Herpes 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 Kidney Problems Leukemia Liver Disease Low Blood Pressure Lung Disease 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 Sicke Cell Disease Sinus Trouble Spina Bifida Stomach/Intestinal Disease Stroke Swelling of Limbs Thyroid Disease Tonsillitis Tuberculosis Tumors or Growths Ulcers Venereal Disease

Have you ever had any serious illness not listed above? 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:

GoSmiles Dental

FINANCIAL AND DENTAL INSURANCE POLICY

We appreciate the opportunity to provide quality dental care to you and your family and we welcome you to our dental family. We would like to acquaint you with our policies regarding dental insurance, financial arrangements, and possible schedule changes.

Since we know it is not always possible to pay your dental bill in full, we would like to explain our financial options. You may choose from the following options that would best suit your needs.

1. Equal payments- equal payments will be determined by the number of visits for each treatment. (First payment due at the start of treatment, second payment due at the second dental visit and thus forward).
2. For your convenience, we have made arrangements to accept payment by *all major credit cards*.
3. Monthly payments- If you need to make monthly payments we offer a safe and secure website to process your payments once a month approved by the office prior to treatment.

Our office fees reflect the commitment and quality of care that our patients deserve. If you have dental insurance, as a courtesy we will complete all the necessary information and submit on your behalf to your primary insurance. *Your estimated co-payment* will be due at the time of service unless other arrangements are made with the office. *Unless we are a participating provider with the carrier, any secondary coverage is the responsibility of the insured.*

If your dental carrier has not made a payment within 60 days of billings, the balance will become your responsibility. You will be billed for any balance due. Insurance coverage is a contractual agreement between the insurance company and you and/or your employer.

We reserve the right to apply a billing charge of *1.5% (18% APR)* on all accounts *90 days* overdue.

A \$32.00 service charge will be added to your account for each returned check to our office due to insufficient funds. If at any time these fees change at our financial institution you are responsible for the current fees for returned checks.

I have read and understand fully the financial options. I understand that in the event my account becomes delinquent I will be responsible for any collections FEE (30%), attorney fees, court cost, and any other charges incurred to collect the account.

Signature of Responsible Party

Date

GoSmiles Dental

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF OUR HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

Go Smiles will use and disclose your personal information to treat you, to receive payment for care we provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care. We have prepared a detailed **NOTICE OF PRIVACY PRACTICES** to help you better understand our policies in regard to protected health information. The terms of this notice may change with time, and we will have copies available for distribution. I acknowledge that I have received, read and understand the **NOTICE OF PRIVACY PRACTICES**.

I also give Go Smiles permission to speak to the following people (if any) regarding my health information.

Name

Relationship to Patient

Name

Relationship to Patient

Patient Name

Signature of Patient/Responsible Party

Date

BROKEN APPOINTMENT POLICY

GoSmiles Dental knows your time is valuable. In fact, we make it a point to schedule all of our patients with respect to your busy schedule. Our daily goal is to seat all of our patients on time. In an effort to provide timely service to our patients we never over-book our schedule like so many other health care facilities. This commitment to your time makes our time very valuable to us as well.

Therefore, the following is the broken appointment policy:

1. All cancellations or rescheduling of appointments must be arranged 48 business hours prior to appointment date.
2. If a broken or cancelled appointment occurs with less than 48 business hour notice, we will apply a \$50 fee to your account.

Thank you for understanding how valuable we consider your time.

Patient / Guardian Signature

Date