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

Physcian`s Name

Physcian`s Number

Emerg Contact Name

Emerg Contact Number

Employer

Address

City

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:

Signature Dental Care

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 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	
Are you on a special diet?	Yes No		
Do you use tobacco?	Yes No		
Do you use controlled substances?	Yes No	If yes	

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	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 Problems	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 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:_____

Signature Dental Care

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. **Client's name**: _____
   First Name Middle Name Last Name
2. **Date of Birth**: ___/___/___ 3. **SSN**: ___-___-____ 4. **Date authorization initiated**: ___/___/___
5. **Authorization initiated by**: Dr. Simona Ziliute at Signature Dental Care
6. **Information to be Used or Disclosed**:
   - ☐ My dental information relating to the following treatment or condition: _____
   - ☐ Most recent ___ years of record
   - ☐ My dental records for the following date(s): _____
   - ☐ Entire dental record
     - ☐ Include ☐ Exclude: My health information related to drug and/or alcohol abuse
     - ☐ Include ☐ Exclude: My health information related to HIV/AIDS
   - ☐ Other information to be used or disclose (describe information in detail): _____

     _____

     _____
7. **Purpose of Use or Disclosure**:
   - ☐ Treatment, Payment or Health Care Operations
   - ☐ Disclosure to Life Insurer for Coverage Purposes
   - ☐ Disclosure to Employer of results of pre-employment physical or lab tests
   - ☐ Marketing Purposes
   - ☐ To the Following Family Members: _____
   - ☐ Other (describe each purpose of the requested use and disclosure in detail): _____

     _____

     _____
8. **This Authorization will:** ☐ **not expire,** ☐ **expire on** ___/___/___ **or upon the happening of the following event**: _____

Authorization and Signature: I authorize the release of my confidential protected dental information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be redisclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected dental information.

Signature of the Client: _____

Signature of Personal Representative: _____

Relationship to Client if Personal Representative: _____

Date of signature: ___/___/___

Signature Dental Care Financial Agreement

It is our goal for our patients to understand their treatment needs as well as their financial responsibility before treatment begins. Please review the following procedures:

Payment Policy

Payment is due at the time services are rendered. If you have dental insurance, your estimated co -pay plus deductible is due at the time of service. If no insurance is involved, payment is expected at each visit.

● We accept **cash, personal checks, Debit cards, Visa, MasterCard, Discover and American Express.**
● Financing available through Care Credit with prior approval.
● A fee will apply for any check that is returned by the bank.
● You will be responsible for any and all costs incurred in the collection of your debt (i.e. collection agency fees, court fees and/or attorney fees).

Dental Insurance

As a courtesy we will gladly file your claims and accept assignment of dental insurance benefits provided you agree to the following:

● You must provide us with an insurance card and/or all of the information necessary to verify your coverage and file your claim.
● Your insurance policy is a contract between you, your employer and the insurance company. Signature Dental Care is not a party to that contract.
● Although we may estimate your insurance benefits, Signature Dental Care is not responsible for their accuracy. Knowledge of your benefits including benefit amounts, limitations, exclusions, waiting periods, etc is entirely your responsibility. Receiving our services indicates your acceptance of responsibility to pay regardless of our estimate.
● ***All charges not paid by your insurance company are your responsibility regardless of the reason for nonpayment***. Not all services Signature Dental Care provide are covered benefits. Benefits differ from one company to another. Fees for non-covered services, along with deductibles and copayments are due at the time of treatment.
● Treatment provided in another dental office during your current plan year may alter your co-payment due for services in our office. In such cases, we are not able to track whether or not you have reached your yearly maximum benefits. Please call your insurance company if this applies to you.
● Please understand that Signature Dental Care responsibility is to provide you with treatment that best meets your needs, not to try to match your care to insurance plan limitations.

Broken or Missed Appointments

To reschedule or cancel an appointment, you must notify us at least 24 hours in advance to avoid a missed appointment fee of up to $50 for every scheduled hour.

I have read and understand this document in the entirety; outlining the office and financial policies of Signature Dental Care and agree to these terms.

Signature of patient or parent/guardian:_____
Date:_____