PATIENT REGISTRATION

ID: _____ Chart ID: _____

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder Preferred Name: _____

☐ Responsible Party

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 Section 3

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.: _____

Additional Comments:

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: _____.00 Rem. Deduct: _____.00

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: .00 Rem. Deduct: _____.00

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 _____

Auburn DENTAL Spa

Privacy Consent

Confidential Channel Communication Request

This form is required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

You have the right to request that communications concerning your personal health information be made through confidential channels. This dental practice will not ask you why you are making your request, and will make reasonable efforts to accommodate all reasonable requests. Some method of contact must be provided and as appropriate information as to how payment will be handled.

I, _____ hereby request that use of the following confidential channels for the communication of information related to my personal health or treatment. This request supersedes any prior request for confidential channel communications I have made.

May we use telephone number (s) and your email address to contact you? Yes No

If not, what telephone number (s) and email address (es) may we use?

_____ _____

May we discuss pertinent information with anyone else? Yes No

If yes, please state name and relationship to you.

Name: _____***Relationship***_____

Name: _____***Relationship***_____

Name: _____***Relationship***_____

Name: _____***Relationship***_____

Acknowledgement Of Receipt

I acknowledge that I received a copy of Auburn Dental Spa's Notice of Privacy Practices.

Patient name _____

Signature _____ *Date* _____

Auburn Dental Spa Office and Payment Policies

The following is an outline of our office and payment policies. We want all of our patients to comfortably afford dental care. Part of our commitment to you is to help contain the ever-rising costs of care. With this in mind, we offer the following financial policy so that you can have the opportunity to decide which payment option best suits your needs. Please acquaint yourself with them and then sign below to acknowledge your understanding and acceptance of them.

FEES

Please feel free to discuss our fees with us at any time. Before any dental treatment begins, the patient and/or responsible party will receive a consultation regarding treatment plan and cost. We attempt to keep our fees at a fair level that reflects the quality of care provided in our office. Prompt payment will enable us to keep our fees lower for everyone; therefore, payment is due at the time services are rendered. For procedures that take multiple appointments to complete, payment may be split up over the number of appointments required.

We accept cash, check, Visa, MasterCard, and Discover. We also offer financing options through Care Credit, a third party finance company, with 12 month interest free plans and extended payment plans with competitive interest rates (WAC). Financing treatment allows you to start your dental care immediately and spread payments over a period of time. You will make payments directly to the financing company and they will pay us for treatment. Qualification is simple and quick. This can be further discussed with our financial coordinator.

INSURANCE

Dental insurance is designed to defray the cost of dental care by covering a portion or percentage of the bill. As a courtesy to our patients with insurance, we will file your insurance claim and allow you to pay only your deductible and/or estimated co-payment as services are rendered.

Keep in mind that the dental insurance companies provide coverage for a limited number of basic services. Unfortunately, some of the dental services that you may need or want will not be covered by your dental insurance carrier. To make sure that you have an optimal dental treatment for your individual condition, the treatment suggested to you will be based on your dental needs. It will not be dictated by your insurance company and their limited coverage.

The benefits that you will receive are based on the terms of the contract that were negotiated between your employer and the dental insurance company. Please remember that the contract is between you and your insurance company, and your total balance in our office is always your responsibility. We make every effort to give you an accurate estimate of what your portion of our fees will be, based on information provided to us. However, we have no way to guarantee the actual terms of your insurance policy. Depending on the type of insurance you have and the exact nature of the plan, you may be responsible for the difference in what the insurance company pays and the fee assessed for services provided. If, for any reason, there is a balance remaining after your insurance company's payment, you will be sent a statement. Disputes regarding reimbursement or the amount of reimbursement are between you and your insurance carrier.

Our dentist office will make every effort to help you understand and make the most of your dental insurance benefits. Please keep us informed of any insurance changes such as policy name, insurance company address, or a change of employment status. Please let us know if you have any questions or concerns.

PAST DUE ACCOUNTS

Account aging begins the day your charges are incurred. Accounts that are 90 days past due will be turned over to a third party collection agency. This action will cause an additional fee of 33.33% of your unpaid balance to be added to your account. We dislike doing this and will do so only if all other efforts to collect your unpaid balance have failed. Once referred for collection, further services will not be provided until the outstanding balance is paid. In the event payment cannot be made in full within the above referenced time frames, please call the office to discuss alternative payment plans. We will make every attempt to accommodate your situation.

We would be happy to work with you to plan the most appropriate arrangements for your budget. We encourage you to contact us promptly should a temporary financial problem arise that may affect payment for your visit. Most importantly we want you to enjoy the benefits of your dental health without the financial strain.

Office Policies

Cancellations of Dental Appointments:

Since appointed times are reserved exclusively for each patient, we ask that you please notify our office 24 hours in advance of your scheduled appointment time if you are unable to keep your appointment. Another patient who needs our care could be scheduled if we have sufficient time to notify them. We realize that emergencies occur, but we ask for your assistance in this regard. If you do not call to cancel and fail to show as scheduled, you may be charged a broken appointment fee of $50.00. If you miss three (3) consecutive appointments, we may request that you seek dental care at another office that can better accommodate your schedule.

I have read, understand and agree to adhere to the office and financial policies outlined above.

Agreement to Pay

I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee including any/all collection agency fees (33.33%), attorney fees and/or court costs, if such be necessary, waiving now and forever the right to claim exemption under the constitution and laws of the State of Alabama, or any other state.

_____ _____

Responsible Party Signature *Date*

Contact Policy

You agree, in order for us to service your account or to collect monies you owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

I/We have read this disclosure and agree that Auburn Dental Spa, its employees and/or agents may contact me/us as described above.

_____ _____

Responsible Party Signature *Date*