PATIENT REGISTRATION FORM

Patient Information

Name: Mr. Mrs. Ms. Miss Dr. First: ________________ MI: _____ Last: ___________________

Address 1: ____________________________________ Address 2: _____________________________________

City: __________________________ State: _________ Zip: _____________

Date of Birth: ______________________ Social Security Number: ____________________________

Marital Status: Married Single Gender: M F Dentist: ________________ Hygienist: ________________

Pre-medicate: Yes No Drug: ________________ Preferred Contact Number: Home Work Fax Mobile

Home: __________________________ Work: _________________________ Fax: _________________________

Mobile: _________________________ Email Address: ____

Emergency Contact Info: First: ___________________ Last: __________________ Phone: ___________________

How were you referred to this office? ____

Guarantor Information

Same as patient: Yes No If No, please complete the following:

Name: Mr. Mrs. Ms. Miss Dr. First: ________________ MI: _____ Last: ___________________

Address 1: ____________________________________ Address 2: _____________________________________

City: ____________ State: _________ Zip: ____________ Phone: Work Home _____________________

Social Security Number: ____________ Gender: M F Rel to Pt: Mother Father Guardian Spouse Other

Insurance Information

Please provide the office with your insurance card so that we may make a copy for your records. Thank you.

Employer: ____________________________ Insurance Company Name: ________________________________

Group/Plan No: ____

Address 1: ____________________________________ Address 2: _____________________________________

City: ____________ State: _________ Zip: ___________ Phone: __________________________________

Subscriber: Same as patient: Yes No Same as guarantor: Yes No If both No, please complete the following:

Name: Mr. Mrs. Ms. Miss Dr. First: ________________ MI: _____ Last: ___________________

Address 1: ____________________________________ Address 2: _____________________________________

City: ____________ State: _________ Zip: ____________ Phone: Work Home _____________________

Rel. to Pt: Spouse Child Other DOB: ______________ SS#: ____________________ Gender: M F

MEDICAL HISTORY FORM

Select Yes or No for the following questions. Your answers are confidential and for our records only. Please note that during your initial visit you will be asked some questions about your responses and there may be additional questions concerning your health.

	Yes No
1. Are you in good health?	
2. Has there been any change in your general health within the past year?	
3. My last physical examination was on	
4. Are you now under the care of a physician?	
If so, what is the condition being treated?	
5. The name, address and phone # of my physician is	
6. Have you had any serious illness, operation or been hospitalized in the past 5 years?	
If so, what was the illness or problem?	
7. Are you taking any medicine(s) including non-prescription medicine?	
If so, what medicine are you taking?	
8. Do you have or have you had any of the following diseases or problems?	
a. Damaged heart valves or artificial heart valves, including heart murmur or rheumatic	
heart disease?	
b. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency,	
coronary occlusion, high blood pressure, arteriosclerosis, stroke)	
i. Do you have chest pain upon exertion?	
ii. Are you even short of breath after mild exercise or when lying down?	
iii. Do your ankles swell?	
iv. Do you have inborn heart defects?	
v. Do you have a cardiac pacemaker?	
c. Allergy	
d. Sinus Trouble	
e. Asthma or hay fever	
f. Fainting spells or seizures	
g. Persistent diarrhea or recent weight loss	
h. Diabetes	
i. Hepatitis, jaundice or liver disease	
j. AIDS or HIV infection	
k. Thyroid problems	
l. Respiratory problems, emphysema, bronchitis, etc.	
m. Arthritis or painful swollen joints	
n. Stomach ulcer or hyperactivity	
o. Kidney trouble	
p. Tuberculosis	
q. Persistent swollen glands in neck	

MEDICAL HISTORY FORM

r. Low blood pressure	
s. Sexually transmitted disease	
t. Epilepsy or other neurological disease	
u. Problems with mental health	
v. Cancer	
w. Problems of the immune system	
x. Joint replacement surgery (i.e. hip or knee) or surgically placed pins	
9. Have you had abnormal bleeding	
a. Have you ever required a blood transfusion	
10. Do you have any blood disorder such as anemia?	
11. Have you ever had any treatment for tumor or growth	
12. Are you allergic to or have you had a reaction to:	
a. Local anesthetics	
b. Penicillin or other antibiotics	
c. Barbiturates, sedatives, or sleeping pills	
d. Aspirin	
e. Codeine or other narcotics	
f. Other	
13. Have you had any serious trouble associated with any previous dental treatment?	
If so, explain	
14. Do you have any disease, condition, or problem not listed above that you think I should know about?	
If so, explain	
15. Are you wearing contact lenses?	
16. Are you wearing removable dental appliances?	
WOMEN	
17. Are you pregnant?	
18. Are you nursing?	
19. Are you taking birth control pills?	

Signature of Patient *Date*

Dental Associates, Ltd.
Financial Policy

Thank you for choosing Dental Associates, Ltd. for your dental care needs.

<u>Policy:</u> **Payment is due in full at the time of service**.

- We accept cash, check, Visa, MasterCard, American Express, and Discover.
- We offer Care Credit as our payment plan option. Please ask the front desk personnel for information.

<u>Additional Charges:</u>

A $35.00 fee will be charged to your account for the following:

- Late payments. Payments are considered late if they are not received within 5 working days of the due date.
- Returned checks.

A minimum of $35.00 will be charged for the following;

- Any cancelled or broken appointment with less than 24 hours notice. In addition a $50 fee will be charged for each subsequent cancelled or broken appointment with less than 24 hours notice.

<u>Collections:</u>

In the event that the patient's account is turned over to a collection agency or attorney, the guarantor is responsible for interest on unpaid balances at a rate of 18% APR and all collection costs, including but not limited to, attorney fees of 30% and an additional $36 collection fee, as well as the unpaid balance on the account.

Thank you for reading our financial policy.

In addition, our office files insurance claims on the patient's behalf as a courtesy; however, we are under no obligation to do so. You, the guarantor, remain ultimately responsible for payment on your account. The patient has the obligation to contact their insurance company to ascertain the status and completeness of any claim. This office is indemnified for any errors or omissions in the filing of claims on the patient's behalf.

I, __________________________ *(guarantor's signature)*, on ______________________ *(date)* have read and agree to the financial policy outlined above.

I have Insurance, What does that mean?

Insurance coverage is a contract between you and the insurance company. As a courtesy to our patients, we will gladly fill out and submit your pre-estimates, x-rays, letters, and insurance claim forms, however; our professional services rendered are charged to YOU, NOT to the insurance company. If your insurance company denies a claim, you will be responsible for the total due.

Thank you for choosing our practice for your dental care needs. We are committed to your treatment being successful and feel that your understanding of your insurance coverage is essential.

Traditional Insurance Plan

A traditional insurance plan pays a flat rate or percentage of your charges. You are responsible for the remainder of the charges that the insurance plan does not cover.

Preferred Provider Organization

A preferred provider organization (PPO) is a type of insurance plan that uses their own list of charges called "allowed fees" or "usual and customary rates" to reimburse you for charges you have incurred. Please note that although you have contracted with a PPO type of insurance plan, this does not signify that our office participates with your PPO plan.

- *If we participate with your plan*:
  We have agreed to accept their allowed fees or usual and customary rates as our charges. You are responsible for the difference between what the insurance plan allows us to charge and what the insurance plan reimburses.
- *If we do not participate with your plan*:
  We are under no obligation to accept what the insurance company determines is allowed or usual and customary. As a result, you are responsible for payment in full what insurance will not cover.

Verifying that we participate with a particular PPO plan is the patients' responsibility.

Dental Management Organization

Dental management organizations, (also know as capitated or managed care plans) that we participate with require us to accept a 'copay' from the patient for a charged procedure. The copay varies by procedure and by plan. We both are bound by their plan to follow their rules; there are times, however, when the best treatment for our patients is not covered by their plan.

Understanding and knowing the plan's coverage is the patients' responsibility.

Dental Associates, Ltd. – Notice of Privacy Practices

THE NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Applicable federal and state law requires Dental Associates, Ltd.:

- to maintain the privacy of your health information.
- to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information.
- to follow the privacy practices that are described in this Notice while it is in effect.

Dental Associates, Ltd., reserves the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request and by posting a copy in each office.

Dental Associates, Ltd., will use and disclose Protected Health Information (PHI) about you for:

- *Treatment* – i.e. disclosing PHI to a physician or other healthcare provider providing treatment to you.
- *Payment* – i.e. disclosing PHI to obtain payment for services we provide to you.
- *Healthcare Operations* – i.e. disclosing PHI for quality assessment and improvement activities, reviewing the competence or qualification of healthcare professionals, conducting training programs, credentialing activities, etc.

Dental Associates, Ltd., will, when required under specific circumstances, use or disclose PHI without the patient's written authorization when:

- *Required by Law* – i.e. disclosing PHI to a correctional institution or law enforcement official
- *Apparent Abuse or Neglect* – i.e. disclosing PHI to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.
- *National Security* - i.e. disclosing PHI to authorized federal officials for lawful intelligence, counterintelligence, and other national security activities and disclosing PHI of Armed Forces personnel to military authorities.

Without written authorization, Dental Associates, Ltd., will not use or disclose your health information for any reason except those described in this Notice.

- If authorization is given, you may revoke it in writing at any time.
- We may disclose your PHI to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.
- We may use or disclose PHI to notify, or assist in the notification of a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death.
- In the event of your incapacity or emergency circumstances, we will disclose PHI based on a determination using our professional judgment disclosing only PHI that is directly relevant to the person's involvement in your healthcare.
- We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, supplies, or x-rays.
- We will not use your health information for marketing communications without your written authorization.
- We may use or disclose your PHI to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

The patient has the right to:

- *Inspect and Copy Records*.
- *Request to Amend Records*. (Dental Associates, Ltd., may deny your request under certain circumstances.)
- *Request Alternative Communication.* You may determine where and when you would like to be contacted.
- *Request Restrictions*. You may place additional restrictions on our use or disclosure of your PHI. We are not required to agree to these restrictions, but if we do, we will abide by our agreement (except in an emergency).
- *Receive an Accounting of Disclosures*. You may receive list of instances in which Dental Associates, Ltd., or our business associates disclosed PHI for purposes, other than treatment, payment, and healthcare operations.

Any request must be made in writing and submitted to the Privacy Officer. The privacy officer will give the patient the correct form(s) to be completed. The forms will be filed in the patient's chart.

If you are concerned that we may have violated your privacy rights or you disagree with a decision we made about access to your health information, you may complain to us using the following contact information. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Dental Associates, Ltd.
12701 Fair Lakes Circle, Ste 500
(703)-269-3187

Dental Associates, Ltd.

ACKNOWLEDGEMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

I, ________________________________, acknowledge that I have received a copy of the
(Print: First and Last Name)

Notice of Privacy Practices from Dental Associates, Ltd.

________________________________ ________________________
Patient or Legal Representative Signature Date

*You may refuse to sign this acknowledgement

For Office Use Only

Reason why acknowledgement could not be obtained:

- ☐ Patient Refused to sign
- ☐ Emergency Situation
- ☐ Other

Explain: ____

________________________________ ________________________
Privacy Officer Signature Date