RX History on Ga. Aware? Yes or No
Date Checked: _____
Patient Chart # _____

PATIENT REGISTRATION

Title: (Mr., Mrs., Ms., Dr.) **Date:** _____
First Name: _____ **M.I.:** ___ **Last Name:** _____ **Prefers to be called:** _____
Date of Birth: _____ **Age:** _____ **Sex: M F** **SSN:** _____
Marital Status: Married Divorced Legally separated Widowed Single
Address: _____
City: _____ **State:** _____ **Zip:** _____
Home phone: ( ) _____ **Cell: ( )** _____ **Work: ( )** _____
Email Address:

Are you employed?: Yes No Full Part time Where: _____
Student status: Yes No Full Part time School Name: _____

Physician: _____ **Dentist:** _____
Pharmacy: _____
How did you hear about our office? (Circle One) Website Phonebook Sign Other: _____
Family/Friend: Who? _____

Name of Parent or Guardian if patient is a minor: _____

Primary Insurance Information
Insurance Co.: _____
Address: _____
_____
_____
Phone: ( ) _____
Coverage: Dental _____ Medical _____
Group Number: _____
Group/Local Name: _____
ID#: _____
Employer: _____
Address: _____
_____

Primary Policy Holder Information
(Person that is employed or first person listed on the insurance policy)
Name: _____
Relationship to patient: _____
Date of Birth: _____ Sex: M F
SSN: _____
Address: _____
_____
_____
Phone: Home: ( ) _____
Cell: ( ) _____
Work: ( ) _____ Ext: _____

Secondary Insurance Information
Insurance Co.: _____
Address: _____
_____
_____
Phone: ( ) _____
Coverage: Dental _____ Medical _____
Group Name: _____
Group/Local Name: _____
ID#: _____
Employer: _____
Address: _____

Primary Policy Holder Information
(Person that is employed or first person listed on the insurance policy)
Name: _____
Relationship to patient: _____
Date of Birth: _____ Sex: M F
SSN: _____
Address: _____
_____
_____
Phone: Home: ( ) _____
Cell: ( ) _____
Work: ( ) _____ Ext: _____

Reason for today's visit: _____

Are you currently under a physician's care? **YES** **NO**
If yes, for what condition(s): _____

Name of my physician(s): _____

Patient Name: _____

GENERAL HEALTH QUESTIONAIRE

PLEASE CHECK **YES OR NO** FOR EACH OF THE FOLLOWING (PLEASE ANSWER ALL QUESTIONS)

Anemia/Thin Blood	☐ YES	☐ NO	Heart Murmur	☐ YES	☐ NO
Angina/Chest pain	☐ YES	☐ NO	Hepatitis/Liver	☐ YES	☐ NO
Arthritis	☐ YES	☐ NO	High Blood Pressure	☐ YES	☐ NO
Artificial joint replacement	☐ YES	☐ NO	Immune Deficiency	☐ YES	☐ NO
Asthma	☐ YES	☐ NO	Kidney or Dialysis	☐ YES	☐ NO
Bleeding problems	☐ YES	☐ NO	Mitral valve prolapsed	☐ YES	☐ NO
Bronchitis	☐ YES	☐ NO	Osteoporosis	☐ YES	☐ NO
Cancer	☐ YES	☐ NO	Psychiatric therapy	☐ YES	☐ NO
Convulsions/seizures	☐ YES	☐ NO	Rheumatic fever	☐ YES	☐ NO
Cough/Cold presently	☐ YES	☐ NO	Stomach Ulcer	☐ YES	☐ NO
Diabetes	☐ YES	☐ NO	Stroke/Weakness	☐ YES	☐ NO
Emphysema	☐ YES	☐ NO	Thyroid problems	☐ YES	☐ NO
Glaucoma	☐ YES	☐ NO	TMJ problems	☐ YES	☐ NO
Heart Attack	☐ YES	☐ NO	Tuberculosis	☐ YES	☐ NO
Cardiac Stent	☐ YES	☐ NO	Gastric Reflux	☐ YES	☐ NO
Radiation Therapy (Head/Neck)	☐ YES	☐ NO	Sleep Apnea	☐ YES	☐ NO

Any other medical problems not listed above: _____

_____

Are you <u>now using</u> or have you <u>ever used</u> drugs such as:
Cocaine, Heroin, Methamphetamine, Others? ☐ YES ☐ NO
Marijuana? ☐ YES ☐ NO

Are you a Smoker? ☐ YES ☐ NO If Yes, How many a day? _____
Are you a Drinker? ☐ YES ☐ NO If Yes, How often? _____

Personal/Family history of unusual reactions or complications to anesthesia or surgery? YES NO
If YES, describe: _____

<u>Medication allergies:</u>			<u>Other Allergies:</u>		
Aspirin	☐ YES	☐ NO	Sulfite preservatives	☐ YES	☐ NO
Codeine	☐ YES	☐ NO	Latex	☐ YES	☐ NO
Iodine	☐ YES	☐ NO	Soy	☐ YES	☐ NO
Penicillin	☐ YES	☐ NO	Sulfa	☐ YES	☐ NO

Other: _____

WOMEN: On birth control pills? ☐ YES ☐ NO <u>(Antibiotics may interfere with these medications)</u>
Currently nursing? ☐ YES ☐ NO
Do you think you may be pregnant? ☐ YES ☐ NO Date of your last menstrual cycle: _____
Do you wish to consult your physician to rule out pregnancy before surgery? YES NO

Recent cortisone/steroid therapy? YES NO

Please list previous surgeries and/or hospitalizations: _____

_____

Please list all medications, pills, herbal medicines: _____

_____

Would you like to discuss any other issues with the Doctor? Yes No

I certify that the above information is correct to the best of my knowledge:

Signature: _____ **Date:** _____
PARENT OR GUARDIAN IF PATIENT IS A MINOR

PATIENT DISCLOSURE INSTRUCTIONS

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (*check all that apply*):

☐ Home Telephone _____

- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Written Communication

- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to my work address
- ☐ O.K. to fax to number indicated

☐ Work Telephone _____

- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Other (Fax/Cell, etc.) _____

I allow you to give my clinical information to or answer questions from (*check all that apply*):

☐ Spouse
☐ Parent
☐ Child
☐ Other (specify): _____
☐ None

EMERGENCY CONTACT:

NAME:_____ RELATIONSHIP:_____

PHONE NUMBER:_____

_____ _____
Patient Signature Date

_____ _____
Print Name Birth date

Financial Policy Guidelines

You are entitled to a clear understanding of your financial obligations before treatment is rendered. A wide variety of services are available in this office, therefore, we do not have a uniform policy that covers all procedures and treatments.

PAYMENT IN FULL IS EXPECTED AT THE TIME SERVICE IS RENDERED. For your convenience, we do accept Visa, MasterCard, Discover, and American Express. We also offer Care Credit financing for qualified patients. **If time allows**, we will check your insurance benefits at time of 1st visit. On subsequent visits, for procedures that are a covered expense under your insurance contract, you will be required to pay the portion not covered by insurance. We do not determine the amount of coverage you receive from your insurance company. If your insurance company has not paid the balance of your account **within 45 days from the date of service**, you will have **15 days** to pay the balance. If your insurance company pays more than the balance due, we will send a refund check to you. You are responsible for any balance left after your insurance company has paid their portion. After completion of service, we will file your insurance for you and we will assist you in trying to receive maximum benefits.

If you want a **pre-determination of benefits**, please make this request at the time of your consultation as this takes time to receive.

Insurance is a contract between **you and your insurance company**. This office is NOT a part of this contract. We will file insurance claims as a courtesy to our patients. We will not become involved in disputes between you and your insurance company regarding what the insurance considers as their "usual and customary charges", deductibles, co-payments, covered charges, or secondary insurance, other than to supply factual information as necessary to the insurance company. **You are ultimately responsible for the timely payment of your account.**

PLEASE BE READY TO PAY FOR TREATMENT WHEN RENDERED. You will be provided with an estimate of fees before the beginning of treatment. If you are unable to pay your portion of payment, we will schedule your treatment at another time.

Patients who schedule and then "break" their surgical appointment (without notifying the office at least 24 hours in advance of the scheduled appointment) will be charged a fee of $100.00. Therefore, please be kind enough to call us if you will not be able to keep your appointment.

By my signature, I have read, or have had this form read to me, and I understand the financial guidelines of the office.

SIGNATURE _____ DATE _____