

PATIENT REGISTRATION



Thank you for selecting our dental team! We will strive to provide you with the best possible care. To help us meet all your dental healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask us- we will be happy to help.

PERSONAL INFORMATION

Name _____ Preferred Name _____
 Male Female Birth date _____ Soc. Sec. # _____
 Minor Single Married Divorced Widowed Separated
Address _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Cell Phone _____
Email _____ Preferred Phone? Home Work Cell
Receive appointment confirmations and continuing care reminders by? Text Email Phone
Employer _____ Occupation _____
Referred by _____

EMERGENCY CONTACT

Name _____ Relationship _____ Phone _____

PERSON RESPONSIBLE FOR ACCOUNT (if different than patient)

Name _____ Male Female Birth date _____ Soc. Sec. # _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Cell Phone _____
Email _____ Employer _____

INSURANCE POLICY HOLDER (if different than patient)

Name _____ Relationship to patient _____
 Male Female Birth date _____ Soc. Sec. # _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Cell Phone _____
Employer _____ Group # _____ Subscriber ID _____
Insurance Company _____ Phone _____
Address _____ City _____ State _____ Zip _____

AUTHORIZATION AND RELEASE

-I authorize the dentist or staff to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or other health practitioners.
-I authorize and request my insurance company to pay directly to the dentist, insurance benefits otherwise payable to me.
-I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of Patient, Parent or Guardian _____ Date _____

CHILD (0-13) MEDICAL HISTORY UPDATE



Patient Name _____
 Today's Date _____ Birth Date _____
 Parent/Guardian Name (s) _____

MEDICAL HISTORY

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.

Is child under a physician's care now? yes no If yes, please explain _____

Has child ever been hospitalized or had a major operation? yes no If yes, please explain _____

Has child ever had a serious head or neck injury? yes no If yes, please explain _____

Is child taking any medications, pills, or drugs? yes no If yes, please explain _____

Is child on a special diet? yes no If yes, please explain _____

Is child allergic to any of the following?

- Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Sulfa Drugs
 Other, please explain _____

Does child have, or has child had, any of the following?

AIDS/HIV Positive	<input type="radio"/> yes <input type="radio"/> no	Cortisone Medicine	<input type="radio"/> yes <input type="radio"/> no	Hemophilia	<input type="radio"/> yes <input type="radio"/> no	Radiation Treatments	<input type="radio"/> yes <input type="radio"/> no
Alzheimer's Disease	<input type="radio"/> yes <input type="radio"/> no	Diabetes	<input type="radio"/> yes <input type="radio"/> no	Hepatitis A	<input type="radio"/> yes <input type="radio"/> no	Recent Weight Loss	<input type="radio"/> yes <input type="radio"/> no
Anaphylaxis	<input type="radio"/> yes <input type="radio"/> no	Drug Addiction	<input type="radio"/> yes <input type="radio"/> no	Hepatitis B or C	<input type="radio"/> yes <input type="radio"/> no	Renal Dialysis	<input type="radio"/> yes <input type="radio"/> no
Anemia	<input type="radio"/> yes <input type="radio"/> no	Easily Winded	<input type="radio"/> yes <input type="radio"/> no	Herpes	<input type="radio"/> yes <input type="radio"/> no	Rheumatic Fever	<input type="radio"/> yes <input type="radio"/> no
Angina	<input type="radio"/> yes <input type="radio"/> no	Emphysema	<input type="radio"/> yes <input type="radio"/> no	High Blood Pressure	<input type="radio"/> yes <input type="radio"/> no	Rheumatism	<input type="radio"/> yes <input type="radio"/> no
Arthritis/Gout	<input type="radio"/> yes <input type="radio"/> no	Epilepsy or Seizures	<input type="radio"/> yes <input type="radio"/> no	High Cholesterol	<input type="radio"/> yes <input type="radio"/> no	Scarlet Fever	<input type="radio"/> yes <input type="radio"/> no
Artificial Heart Valve	<input type="radio"/> yes <input type="radio"/> no	Excessive Bleeding	<input type="radio"/> yes <input type="radio"/> no	Hives or Rash	<input type="radio"/> yes <input type="radio"/> no	Sexually Transmitted Disease	<input type="radio"/> yes <input type="radio"/> no
Artificial Joint	<input type="radio"/> yes <input type="radio"/> no	Excessive Thirst	<input type="radio"/> yes <input type="radio"/> no	Hypoglycemia	<input type="radio"/> yes <input type="radio"/> no	Shingles	<input type="radio"/> yes <input type="radio"/> no
Asthma	<input type="radio"/> yes <input type="radio"/> no	Fainting Spells/Dizziness	<input type="radio"/> yes <input type="radio"/> no	Irregular Heartbeat	<input type="radio"/> yes <input type="radio"/> no	Sickle Cell Disease	<input type="radio"/> yes <input type="radio"/> no
Blood Disease	<input type="radio"/> yes <input type="radio"/> no	Family History of Alzheimer'	<input type="radio"/> yes <input type="radio"/> no	Kidney problems	<input type="radio"/> yes <input type="radio"/> no	Sinus Trouble	<input type="radio"/> yes <input type="radio"/> no
Blood Transfusion	<input type="radio"/> yes <input type="radio"/> no	Frequent Cough	<input type="radio"/> yes <input type="radio"/> no	Leukemia	<input type="radio"/> yes <input type="radio"/> no	Spina Bifida	<input type="radio"/> yes <input type="radio"/> no
Breathing Problem	<input type="radio"/> yes <input type="radio"/> no	Frequent Diarrhea	<input type="radio"/> yes <input type="radio"/> no	Liver Disease	<input type="radio"/> yes <input type="radio"/> no	Stomach/Intestinal Disease	<input type="radio"/> yes <input type="radio"/> no
Bruise Easily	<input type="radio"/> yes <input type="radio"/> no	Frequent Headaches	<input type="radio"/> yes <input type="radio"/> no	Low Blood Pressure	<input type="radio"/> yes <input type="radio"/> no	Stroke	<input type="radio"/> yes <input type="radio"/> no
Cancer	<input type="radio"/> yes <input type="radio"/> no	Genital Herpes	<input type="radio"/> yes <input type="radio"/> no	Lung Disease	<input type="radio"/> yes <input type="radio"/> no	Swelling of Limbs	<input type="radio"/> yes <input type="radio"/> no
Chemotherapy	<input type="radio"/> yes <input type="radio"/> no	Glaucoma	<input type="radio"/> yes <input type="radio"/> no	Mitral Valve Prolapse	<input type="radio"/> yes <input type="radio"/> no	Thyroid Disease	<input type="radio"/> yes <input type="radio"/> no
Chest Pains	<input type="radio"/> yes <input type="radio"/> no	Hay Fever	<input type="radio"/> yes <input type="radio"/> no	Osteoporosis	<input type="radio"/> yes <input type="radio"/> no	Tonsillitis	<input type="radio"/> yes <input type="radio"/> no
Cold Sores/Fever Blisters	<input type="radio"/> yes <input type="radio"/> no	Heart Attack/Failure	<input type="radio"/> yes <input type="radio"/> no	Pain in Jaw Joints	<input type="radio"/> yes <input type="radio"/> no	Tuberculosis	<input type="radio"/> yes <input type="radio"/> no
Congenital Heart Disorder	<input type="radio"/> yes <input type="radio"/> no	Heart Murmur	<input type="radio"/> yes <input type="radio"/> no	Parathyroid Disease	<input type="radio"/> yes <input type="radio"/> no	Tumors or Growths	<input type="radio"/> yes <input type="radio"/> no
Convulsions	<input type="radio"/> yes <input type="radio"/> no	Heart Pace Maker	<input type="radio"/> yes <input type="radio"/> no	Psychiatric Care	<input type="radio"/> yes <input type="radio"/> no	Ulcers	<input type="radio"/> yes <input type="radio"/> no
		Heart Trouble/Disease	<input type="radio"/> yes <input type="radio"/> no			Yellow Jaundice	<input type="radio"/> yes <input type="radio"/> no

Has child ever had any serious illness not listed above? yes no If yes, please explain: _____

Any further information you think we should have: _____

Signature of Parent or Guardian _____ Date _____

(continued on the back)

DENTAL HISTORY

What is the date of child's last dental visit? _____

Has child complained about dental problems? _____

Has child had any unhappy dental experiences? _____

Does child have any mouth habits (thumb sucking, nail biting, etc.)? _____

Has child had any previous injuries to the teeth? _____

Have there been any orthodontic appliances worn now or previously? _____

Does child brush teeth daily? _____ Is fluoride taken in any form? _____

Has your child ever had local anesthetic? _____

Comments _____

Any further information you think we should have:

RESPONSIBILITY AND CONSENT

I hereby authorize and request the performance of dental services for _____. I also give my consent to any advisable and necessary dental procedures, medications, or anesthetics to be administered by the attending dentist or by the supervised staff for diagnostic purposes or dental treatment.

Signature of Parent or Guardian _____

Date _____

MERRY

Dental Care Center, PA



FINANCIAL POLICY AGREEMENT for _____

Print Patient Name

We want to prevent any misunderstandings regarding our office policies, therefore we request that you read and sign this explanation of our policies. Please feel free to ask if you have any questions.

Merry Dental Care Center, PA using the insurance information verified by the patient at their appointment will submit the initial claim to that carrier for each visit, as a courtesy. Insurance coverage is a contract between the insurance carrier and the policy holder. Verification of coverage and eligibility is the patient's responsibility and the patient is responsible to Merry Dental Care Center, PA for all charges incurred. (Merry Dental Care Center, PA will use the birthdate rule for submission of insurance claims with dual coverage carried by separate persons. For patients who are the policy holder on two policies, Merry Dental Care Center, PA will submit the claim on the longest held policy and the secondary forms will be given to the patient for submission.)

All accounts are due 60 days from the date of service. After 60 days balances are subject to a late payment fee of 1.5%/month. Patients with a balance older than 90 days, who have not confirmed a payment arrangement, will be placed on a cash only basis. Merry Dental Care Center, PA may be unable to provide future dental services except for dental emergencies with prepayment of charges. After 90 days all accounts are considered in default. The responsible party agrees to pay all collection costs and reasonable attorney fees incurred in an attempt to collect on this or any future account balances. (Payment options are available upon request.)

Patients occasionally need to miss appointments without advance notice. For this reason we will forgive a single missed appointment. After that, there will be a cancellation fee of \$50/hour for each instance of appointments missed without one business day (24 hrs) notice. This charge is the patient's responsibility and will not be billed to insurance. The office reserves the right to limit or deny appointment privileges to patients with more than 3 occurrences in a 24 month period.

Merry Dental Care Center, PA offers a bookkeeping savings of 5% for payment in full, made by check or cash at the time of service. (By law, this cannot apply for services submitted to insurance.)

In the case of children with custodial arrangements, the parent or guardian who signs the financial agreement will be responsible for all charges incurred.

I have read and understand the financial policies described above.

Signature of Patient or Responsible Party _____ Date _____



HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Patient Name _____ **Today's Date** _____

I understand that under the Health Insurance Portability and Accountability Act (HIPAA) I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and certifications

I acknowledge that, upon request, I can review the *Notice of Privacy Practices* which contains a complete description of the uses and disclosures of my health information. I understand that this organization has the right to change the *Notice of Privacy Practices* and that I can obtain a current copy at any time.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree than you are bound to abide by such restrictions.

Signature of Patient, Parent or Guardian _____ **Date** _____