PATIENT REGISTRATION

MERRY
Dental Care Center, PA

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 _____

o Male o Female Birth date _____ Soc. Sec. # _____

o Minor o Single o Married o Divorced o Widowed o Separated

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email _____ Preferred Phone? o Home o Work o Cell

Receive appointment confirmations and continuing care reminders by? o Text o Email o Phone

Employer _____ Occupation _____

Referred by _____

EMERGENCY CONTACT

Name _____ Relationship _____ Phone _____

PERSON RESPONSIBLE FOR ACCOUNT (if different than patient)

Name_____ o Male o 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 _____

o Male o 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 _____

MERRY
Dental Care Center, PA

FINANCIAL POLICY AGREEMENT for _____

Print 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 $75/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.

_____ _____

Patient or responsible party Date

ADULT MEDICAL HISTORY

MERRY Dental Care Center, PA

Patient Name _____

Today's Date _____ 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?	O yes O no	If yes, please explain _____
Have you ever been hospitalized or had a major operation?	O yes O no	If yes, please explain _____
Have you ever had a serious head or neck injury?	O yes O no	If yes, please explain _____
Are you taking any medications, pills, or drugs?	O yes O no	If yes, please explain _____
Do you take, or have you taken, Phen-Fen or Redux?	O yes O no	If yes, please explain _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	O yes O no	If yes, please explain _____
Are you on a special diet?	O yes O no	If yes, please explain _____
Do you use tobacco?	O yes O no	If yes, please explain _____
Do you use controlled substances?	O yes O no	If yes, please explain _____

Women, are you:

Pregnant/Trying to get pregnant? O yes O no Taking oral contraceptives? O yes O no Nursing? O yes O no

Are you allergic to any of the following?

O Aspirin O Penicillin O Codeine O Acrylic O Metal O Latex O Local Anesthetics O Sulfa Drugs

O Other, please explain _____

Do you have, or have you had, any of the following?

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

Have you ever had any serious illness not listed above? O yes O no If yes, please explain: _____

_____

_____

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 _____

(continued on the back)

DENTAL HISTORY

What is the reason for your visit? _____

When was your last dental visit? _____ When were your last x-rays? _____

Are you having any pain or sensitivity? _____

Does food tend to become caught between your teeth? _____

Do you have any sores or lumps in or near your mouth? _____

Do you clench or grind your teeth? _____

Have you ever experienced any of the following problems in your jaw:

O Clicking O Headaches O Difficulty opening or closing O Pain (joint, ear, side of face)

Have you ever had:

O Braces O Oral Surgery O Gum Treatment O Night Guard O Bite Adjustment O TMJ Treatment

Are you satisfied with the appearance of your teeth? _____

Have you ever had an upsetting experience in the dental office? _____

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 _____

MERRY
Dental Care Center, PA

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 _____