# 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 _____

**Northeast Dental Associates**

**Financial Guidelines & Consent for Treatment**

At Northeast Dental Associates, we strive to make your oral healthcare as affordable as possible. Our financial guidelines allow our patients to be successful not only with the dental treatment they need but also with the financial options which best suit their budget.

**INSURANE:** We will gladly work with you to maximize your contracted benefits. Dental Insurance is an agreement negotiated by your employer (or yourself as an independent subscriber) between you and the insurance carrier. It is designated as a supplement to make your dental care more affordable, not to cover all the costs of care. We will collect your deductible and any estimated portion toward your fees at the time that service is rendered. Our estimate may vary from the actual reimbursement. By signing below, you agree to assign any insurance benefits to Northeast Dental Associates, which are due for any treatment which may be covered. As the patient you are responsible for any charges not reimbursed by insurance. Patients are expected to pay for our services at the time they are rendered. Accounts which have become delinquent 90 days or more will be subject to collections. The patient is responsible for any additional collection costs incurred by Northeast Dental Associates.

**PAYMENT OPTIONS:**

a) **Cash or Check** – As is customary, you many pay with cash or check for payment of fees in our office.
**b) Credit/Debit Cards** – We accept Visa, MasterCard, Discover, and American Express.
**c) Third Party Payment Plans** – Interest-free payment plans up to 12 months are available through third parties based upon several payment options.

**MISSED APPOINTMENTS:** We appreciate and value your time and ask that you do the same for us. We understand things arise and occasionally you may have to reschedule an appointment. We are committed to providing all of our patients with exceptional care. Appointments which are missed or cancelled without prior 24 hours' notice will be subject to a non-refundable fee of $50 added to the account.

**EMERGENCY PATIENTS:** Uninsured patients requiring emergency services will be required to pay for the exam and x-ray(s) prior to being seen. This is a deposit for services rendered.

**RESTORATIVE APPOINTMENTS:** The patient will be asked to pay a deposit to secure an appointment. A deposit in the amount of 50% of the expected procedural cost aside from insurance is required. If the patient cancels the appointment without 24 hours' notice, refunds will be subject to manager's review.

**CONSENT FOR TREATMENT:** I authorize the dentist and staff at Northeast Dental Associates to take radiographs, study models, photographs and other diagnostics aids deemed appropriate to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize Northeast Dental Associates to perform all recommended and mutually-agreed treatment and to employ such assistance as required to provide proper care. Dentists and staff of Northeast Dental Associates are authorized to access and use my electronic healthcare records for the purpose administering my treatment, payment, and related healthcare operations. I agree to the use of anesthetics, sedatives, and other medications as necessary and understand that using anesthetic agents and medication embodies certain risk. I understand that I can ask for a recital of known complications.

Signature _____ Date_____

**Authorization for Release of Protected Health Information**

I authorize Northeast Dental Associates to release my personal Protected Health Information (PHI) as follows:

A) **PHI which may be release:** Name, date of birth, social security number or dental insurance identification number, treatment (proposed, completed, or in progress), progress notes, radiographs, and photographs. Reasonable attempts shall be made to release only the minimal amount of PHI for any transaction or request.

B) **Parties to whom PHI may be Released:** Information may be released, as necessary, to: (1) insurance carriers and any such entities required for processing or collecting payment, (2) another dental or medical practitioner for referral, consultation, (3) family members who have been designated in writing, below, to be informed of your care or treatment, or (4) a different dental practitioner other than Northeast Dental Associates, who requires records of treatment, radiographs, and/or photographs when accompanied by a written authorization of such release from the patient or legal guardian of the patient.

This authorization, if signed, may be revoked later. You may not revoke actions which have already been taken in good faith based upon your current authorization on file with Northeast Dental Associates. Your written notice of revocation must be signed and dated. It may be faxed, e-mailed, or personally delivered to our office.

Your information, properly disclosed by our office, may be re-disclosed by the party receiving it. Healthcare and healthcare related organizations are required by law to abide by these and other provisions of the Health Insurance Portability and Accountability Act (HIPAA). Individuals whom you designate, or others, may not be regulated by law.

Please enter the name(s) of those with whom we may discuss your PHI.

| **Name of Person** | **Relationship to Patient** |
|---|---|
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| | |

By signing below, I certify that I have read and understand this form and have been provided a detailed copy of the HIPAA practices of Northeast Dental Associates to review and/or retain.

Patient/Legal Guardian Signature: _____

Date: _____