Patient Registration Form

PATIENT INFORMATION **Date** _____

□ Mr. □ Mrs. □ Ms. First Name_____ Last Name _____ M.I. _____ Nickname _____

Sex: □ Male □ Female Birth Date_____ Age _____ SSN _____ Email _____

Street _____ City _____ State _____ Zip _____

Home Tel (_____)_____ Cell (_____)_____ Work Tel (_____)_____

Marital Status: □ Single □ Married □ Divorced □ Widowed Previous patient of our practice ? □ Yes □ No Referred by _____

Dentist _____ - Tel (_____)_____ Physician _____ - Tel (_____)_____

Are you currently employed? □ Yes □ No ***If yes*** ** Employer _____ Bus Tel _____ _____

Is your visit today accident related? □ Yes □ No Personal Payment Type □ Cash □ Check □ Credit Card

Who will be responsible/guarantor for your account? (If ***SELF, skip*** to next section)

□ Self □ Spouse □ Father □ Mother □ Other_____

Name _____ _____ Birth Date _____ Tel (_____)_____

Street _____ City _____ State _____ Zip Code _____

Insurance Information

Student: □ Full Time □ Part Time □ No School info _____

□ Married □ Divorced □ Legally Separated □ Widow □ Single _____

Primary *Dental* Insurance	**Primary *Medical* Insurance**
Subscriber Name_____	Subscriber Name _____
Relationship to Patient _____	Relationship to Patient _____
Birth Date _____ SSN _____	Birth Date _____ SSN _____
Street _____City_____	Street _____ City _____
State _____ Zip _____ Phone No. (_____)_____	State _____ Zip _____ Phone No. (_____)_____
Secondary *Dental* Insurance	**Secondary *Medical* Insurance**
Policy Holder _____	Policy Holder _____
Relationship to Patient _____	Relationship to Patient _____
Birth Date _____ SSN _____	Birth Date _____ SSN _____
Street _____ City _____	Street _____ City _____
State _____ Zip _____ Phone No. (_____)_____	State _____ Zip _____ Phone No. (_____)_____

In signing below, I am certifying that the information on this form is true and correct to the best of my knowledge. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered.

SignatureX_____ **Date** _____

Health History

Name _____ Height _____ Weight _____

Reason for today's office visit _____

Are you currently being treated by a physician? □ Yes □ No ***If yes***, please explain _____

Do you have any unhealed injuries or inflamed areas, growths or sore spots in or around your mouth? □ Yes □ No

If yes, please describe _____

Any physical or mental disabilities? □ Yes □ No ***If yes***, please explain _____

Medication

1._____ 3._____

2._____ 4._____

Are you **ALLERGIC** to any medications, food or latex? □ Yes □ No ***If yes***, please list_____

Any previous hospitalizations or surgeries? □ Yes □ No *If yes, please list_____

_____

Women's Section

Are you nursing? □ Yes □ No Are you pregnant? □ Yes □ No *If **YES**, what is your estimated delivery date? _____.

Is there a possibility of pregnancy? □ Yes □ No Are you taking oral contraceptives? □ Yes □ No

Have you had or do you currently have	Yes	No	Have you had or do you currently have	Yes	No
Heart trouble			Asthma		
Heart attack			Bronchitis and/or chronic cough		
Heart surgery			Difficulty breathing and/or lung disease		
Heart valve			Convulsions/epilepsy		
Chest pain/angina			Clinical depression/mental health issues		
Low blood pressure			Blood transfusion		
History of drug and/or alcohol addiction			Tendency to bruise easily		
Fainting spells			Tendency of prolonged bleeding after surgery		
Chronic fatigue			Sleep Apnea		
Diabetes			Jaundice, hepatitis, or liver disease		
Low blood sugar			Dialysis/kidney disease		
Blood disorder (ex. Anemia)			Chemotherapy		
Tuberculosis			X-ray treatment/radiotherapy		
Autoimmune disease			Contagious disease(s) (ex. HIV, AIDS, shingles)		
Malignant hyperthermia			Sexually transmitted disease		
Stomach Ulcers			Tumor(s) and/or growth(s)		
Thyroid Issues			Eye disease (ex. Glaucoma)		
Swollen ankles, arthritis/joint disease			Removable dental appliance		
High blood pressure			Prosthetic joint		
Stroke			Pain and/or clicking of jaw when eating		
Smoke? If yes, packs per day _____			Rheumatic Fever		

Although we do not anticipate any surgical complications, who may we contact in the event of an emergency?

Name _____ **Phone No.** (_____)_____**Relationship to Patient** _____

In signing below, I certify that I have read and understood the questions presented on these forms. I acknowledge that my questions, if any, about the inquiries set forth have been answered to my satisfaction. I will not hold my surgeon, or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of these forms.

Signature X _____ **Date** _____

(Parent or Legal Guardian if minor)

Financial Policy

Our practice makes every effort to provide both individualized and affordable care to each and every patient. An estimate of the charges for any procedure or surgery will be given to you prior to services being rendered.

As a courtesy to you, our office will submit claims to your insurance on your behalf, however please keep in mind that the majority of insurance companies pay fixed allowances for procedures. These allowances and percentages are specific to your insurance contract and vary policy to policy. **If we are in-network providers for your particular insurance policy, we require any co-payments, and deductible amounts to be paid the day services are rendered. If we are not in network with your insurance policy, we require payment in full the day services are rendered.** For those patients that do not carry insurance**, we require payment in full the day services are rendered unless a pre-determination has been submitted**. If you have any questions or concerns, please see a member of our front desk staff.

Delinquent accounts will be subject to collection and the patient or person financially responsible for the account will be responsible for any and all collection costs, attorney's fees, and court costs.

In signing below I acknowledge that I understand the financial policy of Midland Oral Surgery and Implant Centers, LTD. I also authorize the release of information necessary to process my claim and for any insurance payments to be issued to the treating provider. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I agree that the fee for services has been explained to me and is satisfactory.

Our office accepts the following forms of payment: Cash, personal check, credit card (Visa, MasterCard, American Express, Discover). We also offer financing options via CareCredit.

Patient Name (please print) **X** _____

Signature of Patient X_____ **Date** _____

(Parent or Legal Guardian, if minor)

Consent for Release and Use of Confidential Information Receipt of Notice of Privacy Practice Forms

I, _____ hereby give my consent to Midland Oral Surgery and Implant Centers, Ltd. to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in the patient record of _____.
I give permission for Midland Oral Surgery to discuss my bill with _____. I acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information. I understand that the physician has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available via mail or in person. I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

Signature X_____ **Date** _____

(**if <u>not</u> patient**, **please specify your *relationship to patient***) _____

***An attempt was made to obtain a signature of receipt of the physician's Notice of Privacy Practices. This was unsuccessful and is document below.

Date _____ By _____