TIME 9:52 AM DATE 7/18/2012

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

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.:

Section 3

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?
- ☐ Nursing?
- ☐ Taking oral contraceptives?

Are you allergic to any of the following?

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

☐ Other If yes, please explain: _____

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

- ☐ AIDS/HIV Positive
- ☐ Alzheimer's Disease
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Breathing Problem
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Cold Sores/Fever Blisters
- ☐ Congenital Heart Disorder
- ☐ Convulsions
- ☐ Cortisone Medicine
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Easily Winded
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Fainting Spells/Dizziness
- ☐ Frequent Cough
- ☐ Frequent Diarrhea
- ☐ Frequent Headaches
- ☐ Genital Herpes
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack/Failure
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Heart Trouble/Disease
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hives or Rash
- ☐ Hypoglycemia
- ☐ Irregular Heartbeat
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Pain in Jaw Joints
- ☐ Parathyroid Disease
- ☐ Psychiatric Care
- ☐ Radiation Treatments
- ☐ Recent Weight Loss
- ☐ Renal Dialysis
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Spina Bifida
- ☐ Stomach/Intestinal Disease
- ☐ Stroke
- ☐ Swelling of Limbs
- ☐ Thyroid Disease
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors or Growths
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Yellow Jaundice

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: _____

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 _____

OFFICE POLICY FOR FAMILY DENTISTRY

Thank you for choosing us as a dental care provider. We are committed to your treatment being successful. Please understand that payment of your bills is considered part of your treatment. The following is a statement of our Financial Policy which we require you read and sign prior to any treatment. All patients must complete our Registration form before being seen.

PAYMENT IS DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, AMERICAN EXPRESS, AND DISCOVER.

FINANCIAL ARRANGEMENTS MAY BE MADE WHEN EXTENSIVE DENTAL CARE IS NEEDED. (Please see the office manager for more information.)

Regarding Insurance:
We accept most insurance companies. We cannot bill your insurance unless you give us your insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event that your insurance company should deny payment for whatever reason, after every effort that is made by our office to receive payment, the balance becomes that patient responsibility after 45 days. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under your dental insurance. Regarding Insurance Plans where we are a participating provider. All co-pays and deductibles are due at time of treatment. In the event that your insurance coverage changes to a plan where we are not participating providers, refer to above paragraph.

Adult/Minor Patients:
Adult patients are responsible for co-payment at the time of service. The adult accompanying a minor and the parents (or guardians) are responsible for co-payments. For a minor accompanied by other family members, non-emergency treatment will be denied unless charges have been pre-authorized to approved credit card or payment by cash or check at time of service and a note from parent/guardian stating we can treat patient. Minors under 18 years old cannot be treated unless a family member is present or with note from parent/guardian is present.

Missed Appointments:
Unless you cancelled, at least 24 hours advance, our policy is to charge for missed appointments at the rate of $100 per one hour or less scheduled. In the event that the appointment is over one hour, you will be charged accordingly. Our office has a voicemail that is on 24 hours a day, please call as soon as you know you cannot make a reserved appointment we check messages often. Please help us serve you better by keeping reserved appointments.

ATTENTION PERSONAL CHECK WRITERS:
WE DO ALLOW PAYMENY FOR SERVICES TO BE PAID BY PERSONAL CHECK. IN THE EVENT THAT A PERSONAL CHECK COMES BACK UNPAID WE ALSO ASK THAT A CURRENT CREDIT OR DEBIT CARD BE AUTHORIZED ON YOUR ACCOUNT. WE ARE DOING THIS TO AVOID PROSECUTION BY THE WAYNE COUNTY PROSECUTERS. IT IS A CRIME TO WRITE A BAD CHECK. WE ALSO PERFER YOU TO USE YOUR CREDIT OR DEBIT CARD INSTEAD OF A PERSONAL CHECK. IF ACCOUNT IS NOT PAID WITHIN 90 DAYS OF THE DATE OF SERVICE AND NO FINANCIAL ARRANGEMENTS HAVE BEEN MADE, YOU WILL BE RESPONSIBLE FOR LEGAL FEES, COLLECTION AGENCY FEES, INTEREST CHARGES AND ANY OTHER EXPENSES INCURRED IN COLLECTING YOUR ACCOUNT. THANK YOU IN ADVANCE.

Confirmation calls are a courtesy. We make every effort to contact you at the numbers provided. In the event that we cannot reach you by phone, it is still your responsibility to keep reserved appointments.

Time is important to both you and our office. We try our best to stay on time and with your help, we can. For this reason, if you are running behind and cannot get to your appointment on time, please contact our office prior to coming to see if there is still time to complete your treatment. If you arrive 15 minutes or later, you will have to be rescheduled.

Office Hours:
Our hours are by appointment only. The office hours are:

Monday: 10:00am-7:00pm Lunch: 2:00pm-3:00pm
Tuesday: 9:00am-6:00pm Lunch: 1:00pm-2:00pm
Wednesday: 9:00am-1:00pm No Lunch
Thursday: 9:00am-6:00pm Lunch: 1:00pm-2:00pm
Friday: 9:00am-1:00pm No Lunch
Saturday *9:00am-1:00pm No Lunch
*Seasonal September-February

HIPPA – the Health Insurance Portability and Accountability Act.

We also enclose a copy of our privacy policy and by signing this office policy you acknowledge receipt of this document in your new patient packet or if you're a patient of record, this will update your current record.

Thank you for understanding our Financial and Office Policy. Please let us know if you have any questions or concerns.

I have read the Policy and I understand and agree to this Policy.

X_____Date:_____
Signature of Patient of Responsible Party

X_____Date:_____
Signature of Co-Responsibility Party

X_____Date:_____
Dental Team Member (Witness)

FAMILY DENTISTRY & ASSOCIATES OF BELLEVILLE P.C.
PRIVACY POLICY

Dental Practitioners, like all providers of personal financial services, are now required by law to inform their clients of their policies regarding privacy of client information. Dentists have been and continue to be bound by professional standards of confidentiality that are even more stringent than those required. Therefore, we have always protected your right to privacy.

TYPES OF NONPUBLIC PERSONAL INFORMATION WE COLLECT

We collect nonpublic personal and medical information about you that is provided to us by you or obtained by us with your authorization; including by not limited to information from your insurance company, physician(s), and family members or guardians.

PARTIES TO WHOM WE DISCLOSE INFORMATION

For current or former patients, we do not disclose any nonpublic personal information obtained in the course of our practice except as required or permitted by law. Permitted disclosures include, for instance, providing information to our employees, to know that information to assist us in providing services to you. In all such situations, we stress the confidential nature of information being shared.

PROTECTING THE CONFIDENTIALITY AND SECURITY OF CURRENT AND FORMER PATIENT'S INFORMATION

We retain records relating to professional services that we provide so that we are able to assist you with your professional needs and in some cases, to comply with professional guidelines. In order to guard your nonpublic personal information, we maintain physical, electronic, and procedural safeguards that comply with our professional standard.

- Our Office calls the day prior to scheduled appointments to confirm the date and time with you. We may leave this information on voicemail, recording machine or with a family member.