PATIENT REGISTRATION FORM

Patient Information

Name: (Last, First, Middle Initial)	Preferred Name:	Date of Birth:	SSN:
Address:		City, State, Zip	
Email:		Gender: ☐ Male ☐ Female ☐ Transgender	
Cell Phone: ( )		Work Phone: ( )	Home Phone: ( )
Preferred Method of Contact:			
Emergency Contact:	Relationship:	Cell Phone: ( )	Home Phone: ( )
Employer:		Employment: ☐ Full time ☐ Part time ☐ Retired	
Student:		School:	
Preferred Pharmacy Name/ Location:		Pharmacy Phone Number:	
Who may we thank for referring you to our office:			

Dental Insurance: ☐ NOT covered by dental insurance

Dental Insurance Company:		
Are you the policy holder? ☐ Y ☐ N	Member ID #:	Group #:
Policy Holder Name:	If no, then specify: ☐ Spouse/Partner	☐ Parent/Guardian
Policy Holder Employer:	Policy Holder SSN:	Policy Holder DOB:

Do you have Secondary Insurance? ☐ Y ☐ N		
Dental Insurance Company:		
Policy Holder Name:	Sec Policy Holder Member ID#:	Group #
Policy Holder Employer:	Sec Policy Holder SSN:	Policy Holder DOB:

Dental Information - For the following questions, mark (X) your responses to the following questions.

	Yes	No	DK		Yes	No	DK
Do your gums bleed when you brush or floss?				Do you have earaches or neck pains?			
Are your teeth sensitive to cold, hot, sweets or pressure?				Do you have any clicking, popping, or discomfort in the jaw?			
Is your mouth dry?				Do your brux or grind your teeth?			
Have you had any periodontal (gum) treatments?				Do you have sores or ulcers in your mouth?			
Have you ever had orthodontic (braces) treatments?				Do you wear dentures or partials?			
Have you had any problems associated with previous dental treatment?				Do you participate in active recreational activities?			
Is your home water supply fluoridated?				Have you ever had a serious injury to your head or mouth?			
Do you drink bottled or filtered water?				Date of your last dental exam: What was done at that time?			
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY				Date of last x-rays:			
Are you currently experiencing dental pain or discomfort?				What is the reason for your dental visit today?			

MEDICAL HISTORY

PATIENT NAME ____ BIRTHDATE ____________________________

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 If yes, please explain: ______________________________

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ Yes ☐ No

If yes, please explain: ______________________________

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?

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

Have you ever had any serious illness not listed about? ☐ Yes ☐ No If yes, please explain: ______________________________

Comments: ____

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To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangers to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Patient /Guardian Signature ____ DATE ____________________

Doctor Signature ____ DATE____________________

Thank You for choosing Elliott Bay Dental as you dental care provider. Our primary goal is to provide you with the best possible care, without being hindered by the cost of treatment. We will strive to maximize your insurance benefits. Please take your time in reading our Financial Policy. Your clear understanding is important to our professional relationship.

Financial Policy:

Elliott Bay Dental charges what is usual and customary for our area. We will assist you with your benefit eligibility before treatment to help you calculate your costs (Co-Pay) and maximize your insurance. As a courtesy, Elliott Bay Dental will submit the claims necessary so that you receive the full benefits of your coverage, but we cannot guarantee any estimated coverage. Please understand that:

- Payment for a Particular dental service is "**ESTIMATED.**"
- The estimated Payment for all dental services are **DUE AT THE TIME OF SERVICE.**
- The Estimated payment may be **"subject to change"** when the dental service claim is adjudicated by the insurance company.
- Understand your **insurance annual benefits**. If you or your dependents EXCEED your Annual Benefit Maximum, you will be responsible for the cost of all dental services that exceed your plan's benefit
- Understand your insurance plan year (not all insurances are from January to December)
- You are responsible for monitoring your **REMAINING BENEFITS** for the year. Benefits can vary from our records due to use at other offices that we are unaware of.
- The claims we submit to the insurance company indicate that you have assigned those benefits to Elliott Bay Dental. If you are paid by the insurance company, instead of Elliott Bay, then you are responsible for the **TOTAL ACCOUNT BALANCE.**
- Checks that are returned to our office from your financial institution are subject to a **$25.00 returned check fee**. This fee covers the processing fees that are charged to our office.

If you have any questions about your insurance, account, co-pays, or any other general financial questions, please do not hesitate to ask. We will gladly help out, and encourage you to contact us promptly for assistance in the management of your account. Most often, financial misunderstandings can be managed with a phone call.

In addition, we offer CareCredit, a patient payment program offering a full range of No Interest and Extended Payment Plans.

Cancellation Policy:

Our doctors and team members spend a significant amount of time to prepare for your dental visit. Broken and missed appointments create scheduling problems for our team, as well as other patients.

We understand that life happens, so if you need to change your appointment, we require a notice of at least **48 hours** in advance. This allows us to accommodate other patients. If proper notice is not received, a fee of $100 will be charged. Please help us service you better by keeping your appointments.

Signature: ____ Date:____________________________

HIPAA ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES and CONSENT FORM

We at Elliott Bay Dental are required by law to maintain the privacy of our patients Protected Health Information (PHI). Under the Health Insurance Portability and Accountability Act (HIPAA), you have certain rights regarding the use and disclosure of the protected health information. These rights are more fully detailed in our Notice of Privacy Practices, which is attached to this clipboard. You may obtain a copy of this notice upon request.

We are permitted to review and change our Notice or Privacy Practices at any time. We will provide you with any revisions upon request.

Authorization of PHI Disclosure:

- Name of Person #1:___________________________________

  Relationship:____

- Name of Person #2:___________________________________

  Relationship: ____

By signing below, I am acknowledging that I have read the Notice of Privacy Practices. I am also giving Elliott Bay Dental consent to use and disclose protected health information to carry out treatment, payment activities, and other healthcare related operations; including, but not limited to specialty care and prescription medication. I am also giving permission to disclose my protected health information to the person(s) listed above.

Patient Name:____
(Print)

Patient Signature:____________________________________ Date:________________