PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

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

Referred By

Previous Dentist

Emergency Contact

Emergency Contact #

Drivers Lic #

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: Rem. Deduct:

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: Rem. Deduct:

Glynwood Park Dental Care

Eaglesoft Medical History 2020(Copy)

Patient Name: Birth Date: Date Created:

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
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other similar drugs?	◯ Yes ◯ No	If yes
Do you use tobacco?	◯ Yes ◯ No	If yes
Do you take any blood thinners?	◯ Yes ◯ No	If yes
Have you ever had a knee, hip, or any other joint replacement?	◯ Yes ◯ No	If yes
Have you ever been told to take a pre-medication prior to dental treatment?	◯ Yes ◯ No	If yes
Are you taking/using any medications, pills, drugs, or controlled substances?	◯ Yes ◯ No	

** IMPORTANT** PLEASE LIST ALL MEDICATIONS YOU ARE NOW TAKING OR GIVE A COPY OF MEDICATION LIST TO FRONT DESK

Women: Are you...

☐ Pregnant? DUE DATE:_____ ☐ Nursing? ☐ Taking oral contraceptives?

☐ Trying to get pregnant?

Are you allergic to any of the following?

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

Other allergies? ☐ If yes

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

☐ AIDS/HIV Positive	☐ Artificial Joint/ Replacement	☐ Hemophilia	☐ Radiation Treatments
☐ Alzheimer's Disease	☐ Diabetes	☐ Hepatitis A or B	☐ Drug Addiction
☐ Arthritis/Gout	☐ Easily Winded	☐ Hepatitis C	☐ Emphysema
☐ High Blood Pressure	☐ Rheumatism	☐ Herpes	☐ Epilepsy/Seizure/Convulsion
☐ High Cholesterol	☐ Artificial Heart Valve or Pacemaker	☐ Excessive Bleeding	☐ Cortisone Medicine
☐ Hypoglycemia	☐ Sickle Cell Disease	☐ Asthma	☐ Fainting Spells/Dizziness
☐ Irregular Heartbeat/Murmur	☐ Sinus Trouble	☐ Blood Disease	☐ Kidney Problems
☐ Leukemia	☐ Stomach/Intestinal Disease	☐ Frequent Headaches	☐ Liver Disease
☐ Stroke	☐ Bruise Easily	☐ Low Blood Pressure	☐ Cancer
☐ Glaucoma	☐ Lung Disease	☐ Thyroid Disease	☐ Chemotherapy
☐ Mitral Valve Prolapse	☐ Chest Pains	☐ Heart Attack/Failure	☐ Osteoporosis
☐ Tuberculosis	☐ Cold Sores/Fever Blisters	☐ Pain in Jaw Joints	☐ Tumors or Growths
☐ Congenital Heart Disorder	☐ Parathyroid Disease	☐ Ulcers	☐ Heart Trouble/Disease
☐ Psychiatric Care			

Any other health conditions or concerns we should know about? ◯ Yes ◯ No If yes

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:

X Date:_____

GLYNWOOD PARK
DENTAL CARE
David Lieux Jack Bushman Brandon Veach

Office and Financial Policies

Patient Name:_____

PAYMENT POLICY

Payment is due in full the day of treatment.
We accept cash, personal checks, Care Credit, debit cards and all major credit cards
There will be a $25.00 charge for any returned checks.

DENTAL INSURANCE

We will gladly file claims for dental services to your dental insurance carrier; however, all copayments and deductibles will be collected at the time of treatment. Professional services are rendered and charged to you, not your insurance company. Please understand that this contract is between you and your insurance company and payment for services is your responsibility.
Knowledge of benefit amounts, limitations, exclusions, waiting periods, etc. is entirely your responsibility. Receiving our services indicates your acceptance of responsibility to pay regardless of your estimate.

COLLECTIONS

If an account is turned over to our collection agency and/or attorney for collection, the account holder will be responsible for ALL attorneys and/or collection fees that Glynwood Park Dental Care incurs while attempting to collect on an unpaid balance. These collection fees will be added to the outstanding portion of the account, and will also become the financial responsibility of the account holder.

ALTERNATE BENEFITS

I understand that most insurance companies downgrade coverage on non-metal restorations and I agree to the adjusted fees for upgraded materials.

APPOINTMENT/CANCELLATION POLICY

Appointments not kept or changed less than 24 hours notice are considered broken. Please be considerate to the reserved time we have for you and inform us in advance if you need to cancel or reschedule your appointment.
To reschedule or cancel an appointment, you must notify us at least 24 hours in advance to avoid a missed appointment fee of $25.00. We reserve the time to terminate professional treatment of any patient when scheduled appointments are not kept.

I have read and understood this document in its entirety, outlining financial policies and consent including dental insurance, payment policy and appointment policy. I authorize dental treatment and agree to pay all related professional fees. Fees not covered by my dental insurance will be promptly paid upon notification from this office. I acknowledge that I am responsible for all fees necessary to collect my account. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all my insurance submissions. By signing below, I agree to abide by the policies listed above.

Signature: _____ ***Date:*** _____
Parent/Guardian if patient is under the age of 18

HIPAA Notice of Privacy Practices

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent, I authorize *Glynwood Park Dental Care* to use and disclose my protected health information.

A copy of this Notice of Privacy Practices is posted in our waiting room. I understand that by signing this consent form, I am giving my consent to Glynwood Park Dental Care's use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ ***Date:*** _____
Parent/Guardian if patient is under the age of 18