PATIENT REGISTRATION FORM

PRIME DENTAL STUDIO

How did you hear about us? (Check one)

☐ **Location** ☐ **Facebook** ☐ **Instagram**
☐ **Google** ☐ **Yelp** ☐ **Other Internet**
☐ **Family/Friend:** _____
☐ **Other:** _____

Patient Information

First Name: _____ Last Name: _____ Middle Initial: _____
Birthdate: _____ Social Security No: _____ Driver's License No: _____
Email: _____ ☐ I would like to receive correspondence via email
Address: _____ Address 2: _____
City: _____ State: _____ Zip Code: _____
Cell Phone: _____ ☐ Receive Text Reminders Home Phone: _____
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
Parent / Guardian's Employer: _____ Emergency Contact 1: _____
Spouse / Guardian's Name: _____ Phone Number 1: _____
Student Status: _____ Emergency Contact 2: _____
Phone Number 2: _____

Responsible Party (If someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____
Address: _____ Address 2: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Work Phone: _____ Ext: _____ Cell Phone: _____
Birthdate: _____ Social Security No: _____ Driver's License No: _____
☐ Responsible Party is also Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Primary Insurance Information (If uninsured, leave blank)

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other
Insured Social Security No: _____ Insured Birthday: _____
Insurance ID #: _____ Insurance Group #: _____
Employer: _____ Ins. Company: _____
Address: _____ Address: _____
Address 2: _____ Address 2: _____
City, State, Zip: _____ City, State, Zip: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other
Insured Social Security No: _____ Insured Birthday: _____
Insurance ID #: _____ Insurance Group #: _____
Employer: _____ Ins. Company: _____
Address: _____ Address: _____
Address 2: _____ Address 2: _____
City, State, Zip: _____ City, State, Zip: _____

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 interrelationship with the dentistry you 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 medication, pills, or drugs?	○ Yes	○ No	If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes	○ No	
Are you on a special diet?	○ Yes	○ No	
Do you use tobacco?	○ Yes	○ No	
Do you use controlled substances?	○ Yes	○ No	
Do you need to pre-medicate?	○ Yes	○ No	If yes, please explain: _____

Women: Are you pregnant/ trying to get pregnant?	○ Yes	○ No	Taking oral contraceptive?	○ Yes	○ No	Nursing?	○ Yes ○ No

Are you allergic to any of the following?

□ Aspirin □ Penicillin □ Codeine □ Acrylic □ Metal □ Latex □ Local Anesthetics

□ Other If yes to any of the above, please explain:

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

AIDS/HIV Positive	○ Yes	○ No	Excessive Bleeding	○ Yes	○ No	Lung Disease	○ Yes ○ No
Alzheimer's Disease	○ Yes	○ No	Excessive Thirst	○ Yes	○ No	Mitral Valve Prolapse	○ Yes ○ No
Anaphylaxis	○ Yes	○ No	Fainting Spells/Dizziness	○ Yes	○ No	Pain in Jaw Joints	○ Yes ○ No
Anemia	○ Yes	○ No	Frequent Cough	○ Yes	○ No	Parathyroid Disease	○ Yes ○ No
Angina	○ Yes	○ No	Frequent Diarrhea	○ Yes	○ No	Psychiatric Care	○ Yes ○ No
Arthritis/Gout	○ Yes	○ No	Frequent Headaches	○ Yes	○ No	Radiation Treatments	○ Yes ○ No
Artificial Heart Valve	○ Yes	○ No	Genital Herpes	○ Yes	○ No	Recent Weight Loss	○ Yes ○ No
Artificial Joint	○ Yes	○ No	Glaucoma	○ Yes	○ No	Renal Dialysis	○ Yes ○ No
Asthma	○ Yes	○ No	Hay Fever	○ Yes	○ No	Rheumatic Fever	○ Yes ○ No
Blood Disease	○ Yes	○ No	Heart Attack/Failure	○ Yes	○ No	Rheumatism	○ Yes ○ No
Blood Transfusion	○ Yes	○ No	Heart Murmur	○ Yes	○ No	Scarlet Fever	○ Yes ○ No
Breathing Problem	○ Yes	○ No	Heart Pace Maker	○ Yes	○ No	Shingles	○ Yes ○ No
Bruise Easily	○ Yes	○ No	Heart Trouble/Disease	○ Yes	○ No	Sickle Cell Disease	○ Yes ○ No
Cancer	○ Yes	○ No	Hemophilia	○ Yes	○ No	Sinus Trouble	○ Yes ○ No
Chemotherapy	○ Yes	○ No	Hepatitis A	○ Yes	○ No	Spina Bifida	○ Yes ○ No
Chest Pains	○ Yes	○ No	Hepatitis B or C	○ Yes	○ No	Stomach/Intestinal Disease	○ Yes ○ No
Cold Sores/Fever Blisters	○ Yes	○ No	Herpes	○ Yes	○ No	Stroke	○ Yes ○ No
Congenital Heart Disorder	○ Yes	○ No	High Blood Pressure	○ Yes	○ No	Swelling of Limbs	○ Yes ○ No
Convulsions	○ Yes	○ No	Hives or Rash	○ Yes	○ No	Thyroid Disease	○ Yes ○ No
Cortisone Medicine	○ Yes	○ No	Hypoglycemia	○ Yes	○ No	Tonsillitis	○ Yes ○ No
Diabetes	○ Yes	○ No	Irregular Heartbeat	○ Yes	○ No	Tuberculosis	○ Yes ○ No
Drug Addiction	○ Yes	○ No	Kidney Problems	○ Yes	○ No	Tumors or Growths	○ Yes ○ No
Easily Winded	○ Yes	○ No	Leukemia	○ Yes	○ No	Ulcers	○ Yes ○ No
Emphysema	○ Yes	○ No	Liver Disease	○ Yes	○ No	Venereal Disease	○ Yes ○ No
Epilepsy or Seizures	○ Yes	○ No	Low Blood Pressure	○ Yes	○ No	Yellow Jaundice	○ Yes ○ No

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

Do your gums bleed while brushing or flossing?	○ Yes	○ No	Has anyone said you stop breathing while you sleep?	○ Yes	○ No
Are your teeth sensitive to hot or cold liquid/foods?	○ Yes	○ No	Do you clench or grind your teeth?	○ Yes	○ No
Do you feel pain with any of your teeth?	○ Yes	○ No	Have you ever had any difficult extractions in the past?	○ Yes	○ No

Do you like your smile? ○ Yes ○ No If no, please explain: _____

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. By my signature below, I hereby consent to the examination and dental treatment. I understand dentistry is not an exact science and the results of any treatment vary from patient to patient. I understand occasionally additional treatment may be required. I agree that cash payment or credit arrangements for the estimated uninsured portion of treatment will be made at the time of treatment and I agree that the estimate given to me may not be the final or exact amount that I will owe for treatment.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN: _____ DATE: _____

DOCTOR INITIAL: _____

FINANCIAL POLICY AND OFFICE POLICIES

FINANCIAL POLICY

We are proud to be part of a team whose primary mission is to deliver the finest and most comprehensive dental care available today. In addition, we are also dedicated to making top-quality care as cost-effective as possible. To assist you with your healthcare investment, we provide the following payment options:

1. Cash – includes money orders and personal checks
2. Credit Card / Debit Card – we accept all major credit cards as payment for your treatment
3. CareCredit – the financing plan we offer as a separate line of credit to cover you and your family members' healthcare needs. Ask for more details if interested.

Patients who are not covered by insurance are expected to pay with cash, credit card, or use your CareCredit account the day the service is rendered.

For patients that are covered by insurance, we will honor the assignment of benefits. This means that the insurance company will pay their portion to our dental office. Most dental insurance plans do not cover 100% of the cost of treatment. Because of this, and the extreme delay in receiving payment from the insurance company, you will be asked to pay your deductible and your portion of the charges the day the service is rendered. **We will estimate your coverage as closely as possible, but until we actually receive the payment from the insurance company, it is just an estimate.** The staff will assist you in dealing with your insurance company, but the ultimate responsibility lies with you. If the insurance company does not cover the estimated amount in full, you will receive a statement in the mail and you will be responsible for the remaining account balance. After 60 days, the balance will be due in full from you.

I have read and understand the Financial Policy.

_____	_____	_____
Patient/Parent/Guardian Name (Printed)	Patient/Parent/Guardian (Signature)	Date

OFFICE POLICIES

Our goal is to provide top-quality dental care in a timely manner. In order to do so we have implemented the following office policies to help us better utilize available appointments for our patients.

48-Hour Cancellation Policy: A no-show fee of $40.00 will be added to your account if you do not give us at least 48 hours notice prior to cancelling your appointment.

Late Arrivals: In the event you are running late for your scheduled appointment, please call the office. If you are more than 15 minutes late to your scheduled appointment you may be asked to reschedule.

Emergency Care: Patients are seen promptly at their appointment times. Occasionally we will have to accommodate a patient in discomfort or in any other emergency situation that may effect your reserved appointment time. This courtesy is extended to you and all patients and we ask for your understanding when these unexpected situations arise. Out of respect for your time, we will keep you informed of such emergencies. We thank you in advance.

I have read and understand the Office Policies.

_____	_____	_____
Patient/Parent/Guardian Name (Printed)	Patient/Parent/Guardian (Signature)	Date

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____ Date of Birth: _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

HIPPA Release: By signing this form, I _____ authorize the release of information to the
(Patient/Guardian Name)

following individual(s): _____,
including the diagnosis, records, examination, ledgers and billing, claim information, and treatment rendered to the above patient.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of your Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

CONTACT PERSON:	HIPAA Control Officer
TELEPHONE:	405-359-0808
E-MAIL:	miker@catalystdds.com
ADDRESS:	3901 E. Covell Rd., Edmond, OK 73034

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

_____ _____
Signature Date

==========

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You may refuse to sign this acknowledgment.

I _____ have received a copy of this office's Notice of Privacy Practices.

_____ _____
PLEASE PRINT NAME SIGNATURE