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

Referred by: _____

Text Confirm: Y/N: _____

V-mail Confirm: Y/N: _____

Work Confirm: Y/N: _____

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

Spring Lake Dental Group
David G. Dickerhoff, DDS & Associates, PA

Patient Name: _____ **Account #**_____ **Date:** _____

This is a questionnaire to assess your current status in achieving optimum oral health. Please take a moment to give your health care professionals the information they need to assess your health status as thoroughly as possible.

Approximately when was your last dental cleaning? _____

Was it a regular cleaning **(Y) (N)** or a periodontal or deep cleaning **(Y) (N)**

Do you floss? **(Y) (N)** How often?_____

Do you use any other dental aides? Circle those that apply.

Toothpicks	Floss threaders	Interdental brushes	Superfloss
Reach flosser	Disposable flossers	Gum stimulators	Fluoride tablets
Tongue scrapers	Salivary substitutes	Xylitol chewing gum	
Sensitivity toothpastes	High fluoride toothpastes		

Do you use mouthwash? **(Y) (N)** If so, what brand is it?_____

What brand of toothpaste do you use?_____

What type of toothbrush do you use? Manual Electric Sonic

If you answered 'manual', are the bristles? Hard Medium Soft I don't know

Any dexterity problems with the use of your hands? **(Y) (N)**

Do you have sensitive teeth? **(Y) (N)** top right top front top left all over

bottom right bottom front bottom left

Have you ever worn braces? **(Y) (N)**

If so, do you currently wear retainers? **(Y) (N)** Top Bottom Bonded in

Do you like your smile? **(Y) (N)** If not, what would you change?_____

Have you ever whitened your teeth? **(Y) (N)** What did you use to whiten them? _____

Were you satisfied with the results? **(Y) (N)**

Does your jaw 'pop' or 'click' when you chew or talk? **(Y) (N)**

Do you clench or grind your teeth? **(Y) (N)**

Do you experience morning headaches? **(Y) (N)**

Do you have any pain or soreness in your jaw muscles or joint? **(Y) (N)**

In respect to dental anxiety or fears about being treated in a dental office, where would you rate your anxiety on a scale of 1 to 10 with ten being extremely frightened and uncomfortable? _____

Do you have a problem or issue that you would like addressed today? If so, what is it?

_____

_____

Please feel free to ask your questions and get comfortable with our recommendations for your care. We thank you for choosing our dental office.

Account #_____

Spring Lake Dental Group
Financial Arrangements and Dental Insurance

We are committed to providing you with the best possible care. Our staff works as a team to provide dental expertise as well as old fashioned courtesy and compassion. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

Payment for service is due the time services are rendered. We accept cash, VISA, Master Card, debit cards, CareCredit, and in state checks. A treatment plan for all dental work will be established before treatment begins. If you have dental insurance, we are willing to help you receive your maximum allowable benefits. As a courtesy to our patients, we will file and accept payment directly from your insurance company. Since most insurance companies do not pay 100%, you are responsible for your cost-share at the time of your appointment. Our office will estimate your co-payment before treatment. **Please keep in mind that this is merely an estimate.**

Children under the age of 18 must be accompanied by a parent or legal guardian to every appointment. If the parent or legal guardian is unable to accompany the child, we will accept a written note with the parent or legal guardian's signature allowing another adult to authorize care for your child. The parent that accompanies the child is responsible for any payments due at the time services are rendered. We will not bill the other parent.

Returned checks and balances older than 30 days are subject to additional collection fees and interest charge of 1½ % per month. **We request at least 24 hours notice to reschedule a non-specialty appointment and 48 hours notice to reschedule a specialty appointment to avoid a rescheduling fee. Failed appointments are assessed a fee.**

While the filing of insurance claims is a courtesy that we extend to our patients, please realize:

1) Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
2) Insurance may pay all, some, or none of your bill. Your portion is due at the time of the appointment. If your insurance does not make payment within 30 days, you will be billed for the unpaid balance.
3) Not all services are covered benefits in all contracts. Some companies do not cover certain services. Please familiarize yourself with your insurance plan limitations, frequencies, waiting periods, and maximum coverage amounts, as benefits vary.

We must emphasize that as dental care providers, our relationship is with you, not the insurance company. We realize that temporary financial problems may affect timely payment of your account. If such problems arise, do not ignore bills you cannot pay. Instead, promptly contact us for assistance in managing your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage. PLEASE don't hesitate to ask us. We are here to help you!

I hereby authorize David G. Dickerhoff, DDS & Associates, P.A. to submit and assign benefits on my behalf to _____Insurance Company(ies), and to release information relative to dental claims. I also authorize payment of my dental insurance benefits, otherwise payable to me, to Spring Lake Dental Group, David G. Dickerhoff, DDS & Associates, P.A.

Patient's Name:_____ Date:_____

Patient/Parent/Legal Guardian's Signature:_____

Spring Lake Dental Group
David G. Dickerhoff, DDS & Associates, PA

103 Superior Drive * Spring Lake, NC 28390
Office: (910)497.3200
Fax: (910)497.2209

NOTICE OF PRIVACY PRACTICES PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice also contains a patient rights section describing your patient rights under the law. You have a right to review this Notice before signing this form. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or healthcare operations. We are not required to agree to this restriction but if we do, we shall honor the agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for:

1. Treatment (including direct and indirect treatment by other healthcare providers involved in your medical and dental care;
2. Payment from your insurance company or other third party payers;
3. The day-to-day healthcare operations of Spring Lake Dental Group.

As the patient:

I understand that I may request in writing that Spring Lake Dental Group restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that Spring Lake Dental Group is not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

I understand that I may revoke this Consent in writing at any time, except that you have taken action relying on this Consent.

_____ _____

Patient's Printed Name Patient, Parent or Legal Guardian's Signature

Relationship to Patient: _____

Date: _____

Spring Lake Dental Group
David G. Dickerhoff, DDS & Associates, PA

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AUTHORIZATION FOR RELEASE OF INFORMATION

Patient's Name_____ Date of Birth_____

Spring Lake Dental Group is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information Check each person/entity that you approve to receive information.	**Description of Information to be Released** (i.e., all information; appointments only; account &financial information only; medical history only)
___ Spouse (Provide name) _____	_____
_____	_____
___ Parent (Provide name of each parent) _____	_____
_____	_____
___ Other (Provide name and relationship) _____	_____
_____	_____
_____	_____
_____	_____

I give permission to leave appointment information on my: ____ home voicemail; ____ at work; ____ through text messaging and/or ____ via email. (Check all that apply.)

Text number _____

E-mail address _____

Patient Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I, understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. **This authorization shall be in effect until revoked by the patient or legal guardian.**

_____ _____

Signature of Patient, Legal Guardian or Personal Representative Date

Account number _____