LAKE JEANETTE FAMILY DENTISTRY
REGISTRATION FORM

(Please Print)

Today's date:

PATIENT INFORMATION

Last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Preferred name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ( )

City:	State:	Zip Code:	Cell Phone no: ( )

E-mail	Employer:	Employer phone no.: ( )

Referred by (please check one box): ❑ Dr. Other family members seen here: _____

❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Best way to reach you: _____txt _____phone _____e-mail

INSURANCE INFORMATION

(Please provide your insurance card)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Employer:		Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group #:	ID #:	

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group #:	ID #:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the office of Dr. Eric j. McCollum. **I understand that I am financially responsible for any balance for services rendered**. I also authorize Lake Jeanette Family Dentistry or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

Time 1:08 PM

Lake Jeanette Family Dentistry

Eaglesoft Medical History

Date 2/26/2018

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, c

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 had a serious head or neck injury?	Yes No	If yes
Are you taking any medications, pills, or drugs?	Yes No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Are you on a special diet?	Yes No	
Do you use tobacco?	Yes No	
Do you use controlled substances?	Yes No	If yes

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 ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

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

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

Have you ever had any serious illness not listed above? Yes No If yes

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:

X_____ Date:_____

Patient's Dental History

Patient's Name_____D.O.B._____

Reason for this visit_____

When was your last dental visit_____what was done_____

How often did you visit the dentist before then_____

Previous Dentist (name/city/state)_____

Have you had a complete set of dental x-rays, when/where_____

How often do you brush your teeth_____floss_____

Is your drinking water fluoridated	yes	no
Do your gums bleed while brushing or flossing	yes	no
Are your teeth sensitive to hot or cold food/liquid	yes	no
Are your teeth sensitive to sweet or sour food/liquid	yes	no
Do you feel pain in any of your teeth	yes	no
Do you have any sores or lumps in your mouth	yes	no
Have you had any head, neck or jaw injuries	yes	no
Have you experienced any of the following problems		
In your jaw: click	yes	no
Pain (joint/ear/side of face)	yes	no
Difficulty in opening or closing	yes	no
Difficulty in chewing	yes	no
Do you have trouble chewing	yes	no
Do you have frequent headaches	yes	no
Do you clench or grind your teeth	yes	no
Do you bite your lips or cheeks frequently	yes	no
Does food get caught between your teeth	yes	no
Have you ever had periodontal treatment (gums)	yes	no
Ever worn a bite plat or other appliance	yes	no
Have you ever had prolonged bleeding after an extraction	yes	no
Do you wear dentures or partials	yes	no
Have you ever received oral hygiene instructions	yes	no

If you could change **anything** about your smile, what would you change?_____

_____

Lake Jeanette Family Dentistry
HIPAA Release Form

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL/DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information used or disclosed to us in any form be kept confidential. The federal law gives you the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. Without specific written authorization, we are permitted to use and disclose your health care records for the purpose of treatment, insurance, payment, and health care operations. In addition, we may use your confidential information to remind you of appointments by sending reminder postcards and/or leaving messages at home or work. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent we have already taken actions relying on your authorization.

For more information about our Privacy Practices, please contact our office

I have reviewed the Lake Jeanette Family Dentistry Notice of Privacy Practices and understand that more information is available upon request. I also certify that I have read and understand the above information to the best of my knowledge. I authorize the release of any information, including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such dental care to third party payers and/or health practitioners. I also give Lake Jeanette Family Dentistry permission to discuss or release my records to the names listed below. If no other individuals are to receive information, please place **NONE** in the spaces below.

NAME_____RELATIONSHIP_____

NAME_____RELATIONSHIP_____

NAME_____RELATIONSHIP_____

PATIENT_____

Signature of Patient/Guardian_____Date_____

No expiration until required by law

Lake Jeanette Family Dentistry

Financial Policy

Thank you for choosing us for your dental healthcare needs. We are committed to providing you high quality, comprehensive care in a comfortable and friendly atmosphere. Please read, ask us any questions you may have, and sign in the space provided.

Identification - All new patients must present with a valid photo ID at the first appointment.

Insurance - We must obtain current **Dental** insurance information prior to your appointment. If we are unable to verify current Dental insurance coverage, payment in full is due at time of service.

Claims submission: We will submit your claims promptly and assist you in any way we reasonably can to help get your claims paid. The balance of claims is your responsibility whether or not your insurance company pays the claim. Please be aware, most insurances have time restrictions for filing claims that, if delayed, can render them ineligible for payment. Therefore, if additional information is requested, your prompt assistance is necessary.

Note: An insurance policy is a contract between you and the insurance company.

Coverage changes: If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

Missed appointments - Our policy is to charge $40 for missed appointments that are not canceled within 24 hours of the appointment time; fee may be higher for treatment appointments where a significant amount of time has been reserved. These charges will be your responsibility and billed directly to you. Reasonable exceptions are considered. Please help us to serve you and all patients better by keeping your regularly scheduled appointments or providing us sufficient notice.

Payment/Statements - The patient's estimated portion is due at time of service. Any alternative financial arrangements are to be made prior to scheduling and receiving services. Should there be a balance due after payment is received from insurance, a statement will be issued. Please promptly submit payment to our office within 30 days before late fees accrue.

Delinquent accounts: If your account becomes 90 days past due we will pursue collection actions; in which case, additional fees may be incurred.

Insurance payments sent to patients - On occasion, insurance companies will erroneously send payments directly to patients rather than to our office. Please promptly turn over any insurance checks received within 30 days of receipt; if delayed, full payment will be expected for any future appointments. Please note, failure to turn over such payment is considered insurance fraud, which we are compelled to report accordingly.

I have read and understand the payment policy and agree to abide by its guidelines:

Signature of patient or responsible party **Date**

Lake Jeanette Family Dentistry

3810 N. Elm Street
Suite 201
Greensboro, NC 27455

I_____(print name), hereby authorize the release of my dental records to:

Lake Jeanette Family Dentistry
3810 N. Elm Street
Suite 201
Greensboro, NC 27455
Fax: (336)217-7989
ljfamilydentistry@gmail.com

_____signature

_____date