TIME 04:27 PM DATE 2/9/2022

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

Emergency Contact _____

Emergency Contact # _____

Previous Dentist _____

Physcian's # _____

Physcian's Name _____

Last Dental Visit _____

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: _____

Eaglesoft Medical History

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 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: _____

Family Dental Care

Barry G. Sorenson and Joseph C. Johnson

Financial Policy

Thank you for choosing Family Dental Care as your dental care provider. We are committed to your treatment being successful. The following is an outline of our "financial Policy." It is our intention to inform our patients as clearly and completely as possible as to our guidelines of payment for services rendered. It is our hope that openly discussing our financial policy will prevent future financial misunderstandings.

Payment Policy:

Payment is due at the time of service.

If you are unable to pay at the time of service, your appointment will need to be rescheduled. We take VISA, Mastercard, American Express, Discover, cash, personal checks or CARE CREDIT. This office charges a convenience of 3.5% for all credit card purchases.

Insurance and Insurance Collection:

Please understand that insurance reimbursement can be a long and difficult process for our office. In fact, insurers routinely stall, deny, and reduce payments. To that end, our billing staff has undergone training to maximize your insurance reimbursement, while reducing the time by which they pay.

Please note that we can only ever give you an estimate of how your insurance will pay on your behalf, and that you are ultimately responsible for knowing and understanding your Dental Insurance Plan. We are more than happy to bill our insurance as a courtesy to you. In the event that your insurance company does not reimburse within 60 days, the balance will be your responsibility.

Non-Covered Services

Dental Benefit Plans are designed to pay for some but not all dental care costs. Non-covered services are services not included in your dental plan contract. You can be charged directly for these services. You will be informed at the time of service what these charges will be.

Secondary Insurers:

Having more than one insurer DOES NOT necessarily mean that your services will be covered at 100%. Secondary insurers will pay only a certain percent based on what your primary insurance has paid. We may bill your secondary insurance carrier as a courtesy; however, you are responsible for any outstanding balance after your insurance(s) have paid.

UCR, or Usual and Customary Rates:

Our practice is committed to providing the best treatment for our patients and *we charge what is usual and customary in our area.* You are responsible for payment regardless of the insurance company's arbitrary determination of usual and customary rates.

Divorce Decrees:

This office is not a party to your divorce decree. Adult patients are responsible for their bill at the time of service. The responsibility for minors rests with the accompanying adult. We will not collect separately from each parent.

Returned checks:

Any returned check will be billed back to your account with a $25.00 service charge. We do not automatically re-deposit NSF checks without first speaking to the patient.

Finance Fees:

We are not a billing company. We reserve the right to charge interest in the amount of 1.4% as provided by state law.

Appointments:

Please remember that once an appointment has been made *this time is reserved specifically for you.* We kindly request at least 24 business hours' notice should you have to reschedule or cancel an appointment. Missed appointments are subject to a $75.00 fee.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree with this financial Policy.

Signed_____ **Date** _____

(Patient or Responsible Party)

Signed_____ **Date**_____

(Co-Responsible Party)

Family Dental Care

Barry G. Sorenson and Joseph C. Johnson

FINANCIAL CONTRACT/AGREEMENT

1. I understand that if I do not pay my account with Family Dental Care in full that my account may be assigned to a collection agency for collection.

2. I understand that if my account is assigned to a collection agency, that the collection agency will charge a commission or fee that may be as much as 40 percent of the amount I owe to Family Dental Care. I agree that if my account is assigned to a collection agency that Family Dental Care may add the amount of the Collection Agency's commission or fee to the amount that I owe, and I agree to pay that additional amount.

3. I understand that the addition of a collection agency's fee or commission to my unpaid balance may well result in my owing a sum substantially in excess of the amount owed for dental services. I understand, for example, that if the unpaid balance that I owe to Family Dental Care is $1,000.00, that Dr. Sorenson may add up to $400 to my account, and I agree to pay the sum of $1,400.00 in such event.

4. I understand and agree that in the event legal action is commenced to enforce my obligations hereunder, that I will pay court costs and reasonable attorney's fees.

_____ _____

Signature of Patient or Guarantor Date

Family Dental Care

Barry G. Sorenson and Joseph C. Johnson

Acknowledgement of Receipt of Notice of Privacy Practices

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of Family Dental Care's Notice of Privacy Practices.

Print Name _____

Signature _____

Date _____

Please list name of Personal Representative, or those with whom we can discuss your information or care _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual Refused to Sign

☐ Communication Barriers Prohibited Obtaining Acknowledgement

☐ Other (Please Specify below)

_____

_____