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 #

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:

Veritas Dental

Eaglesoft Medical History

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:_____

VERITAS DENTAL
COVID-19 CONSENT FORM

I knowingly and willingly consent to have dental care completed during the COVID-19 Pandemic.

I understand COVID-19 has a long incubation period, which carriers of the virus may not show symptoms and may still be highly contagious.

Dental procedures create water spray which is how the disease is spread. The ultra-fine nature of the spray can linger in the air for minutes to sometimes hours, which can transmit the COVID-19 virus.

I have been made aware of the CDC, ODA and ADA guidelines under the current pandemic. I understand that Dr. Trinh is taking every precaution outlined by the CDC, ODA and ADA in order to keep our patients and staff protected.

I confirm that I have not experienced any of the following symptoms of COVID-19:
- Fever
- Shortness of breath
- Dry Cough
- Runny Nose
- Sore Throat

_____ (initial)

I confirm that I have tested for COVID-19:
- Date of test _____
- Negative _____ Positive_____
- If positive, date quarantine period ended: _____

_____ (initial)

Signature: _____ Date: _____

Health Insurance Portability and Accountability Act (HIPAA)

PATIENT ACKNOWLEDGEMENT

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement but, in refusing we *will not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices _____. A copy of this signed, dated Acknowledgement shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST DOCUMENTS BE SENT TO OTHER ATTENDING DOCTOR / TREATMENT FACILITIES IN THE FUTURE.**

_____ _____

Please ***print*** name of Patient Please ***sign*** for Patient / Guardian of Patient

_____ _____

Legal Representative / Guardian Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents: _____

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

☐ First Name Only ☐ Proper Sir Name ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTHCARE INFORMATION:
(This includes and any care takers, step parents, grandparents who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE **INFORMATION ABOUT MY HEALTHCARE** BE CONVEYED VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I APPROVE BEING CONTACTED ON BEHALF OF THIS PRACTICE VIA:

□ Phone Message
□ Text Message
□ Email
☐ **Any of the Above**
☐ **None of the Above (opt out)**

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this pharmacy may recommend products or services to promote your improved health. This pharmacy may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

___ It was emergency treatment
___ The patient refused to sign
___ Other (please describe)
___ I could not communicate with the patient
___ The patient was unable to sign because

_____

Signature of Privacy Officer

Financial Policy

Veritas Dental
599 Carle Ave
Lewis Center, Ohio 43035

We are pleased you chose our office to facilitate and care for your dental needs. The following is our financial policy, which we kindly ask you to read and agree to prior to treatment.

Payment Options

1. We accept Cash, Checks, Amex, Discover, Mastercard, Visa and Bank Debit Cards.

2. We offer extended payment plans with no interest through third party financing with Care Credit to those who qualify.

3. Other financial arrangements are reserved for major work to be performed over $2,000. We will be happy to discuss these options with you if the situation applies.

Insurance

For those patients who have financial assistance from insurance, your estimated co-insurance amount is due at time of service. We will continue to submit your claim for you; however, your insurance is a contract between you, your employer, and the insurance company. As your dental provider our relationship is with you, not the insurance company.
All charges incurred are the responsibility of the patient regardless of your insurance coverage. We will cooperate fully with the regulations and requests of your insurance company that my assist in your claim being paid. Disputes or denied claims should be directed to your insurance carrier and/or employer.
Insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurance company has not made payment within 30 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received within 60 days from the date of filing, or your claim is denied, you will be responsible for paying the full amount at that time. If we receive any payment from your insurance company and you have paid your bill in full, we will remit the payment directly to you.

Emergency Patients

We require full payment for those seen for emergency appointment. We will file any insurance claims and reimbursement directed to you for this initial visit. Once established as a patient of record we will then only require your co-insurance at time of service.

Minors of Separated or Divorced Parents
When two parents are each responsible for portions of a child's dental care, the parent or guardian who brings the child is responsible for co-insurance or full fee at time of service. They are also responsible for collecting payment from the other parent. Pre-arrangements must be made with our office if another party will be bringing the child to their appointment.

Returned Checks/NSF
A $25.00 fee will be assessed for all returned or NSF checks.

I have read and understand the financial policies of Dr. Huong Trinh. I understand I am responsible for all fees incurred for my dental treatment.

_____ *Patient initials*

I understand insurance plans are payment assistance programs; they are not designed to cover the entire cost of treatment. I understand my insurance carrier may pay less than the actual bill for services. By signing I authorize assignment of benefits directly to Dr. Huong Trinh and this practice.

_____ *Patient initials*

I understand I am responsible for any and all charges that might occur if my account is turned over for collections.

_____ *Patient initials*

Signature: _____ *Date:* _____

Parent or Legal Guardian: _____ *Date:* _____

VERITAS DENTAL

Appointment Policy

- **We need *48 hours notice* if you are unable to keep your appointment**
- **There will be *a $50 charge* for any appointment missed without notice**

To provide the best dental care for our patients, we strive to stay on schedule. If you should happen to be delayed for some reason, please call the office. There is a chance we may still be able to see you, or we may have to reschedule. We thank you in advance for your cooperation with these policies.

Patient or Legal Guardian Signature: _____ Date: _____