PATIENT REGISTRATION

First Name _____ **Last Name** _____ **Middle Initial** _____

Responsible Party if someone other than the patient:

Name_____

Address_____

City_____ State _____ Zip Code_____

Home Phone_____ Cell Phone _____ Wk Phone_____

Date of Birth_____ SS#_____ Driver's License #_____

Email_____

Responsible party is also a policy holder for the patient _____Primary _____Secondary

Patient Information:

Name_____ Preferred Name_____

Address_____

City_____ State_____ Zip Code_____

Home Phone_____ Cell Phone_____ WK Phone _____

Date of Birth_____ Age_____ Male_____ Female_____ Single_____ Married_____

Email _____

Primary Insurance Information:

Employer: _____ **Occupation:** _____

Name of insured_____ Relationship to patient ___self ___Spouse___ Child ___ Other

Insured SS#_____ Insured Date of Birth_____ Insurance Company_____

Group # _____ Insurance Company phone # _____

Secondary Insurance Information:

Employer: _____ **Occupation:** _____

Name of insured_____ Relationship to patient ___self ___Spouse___ Child ___ Other

Insured SS#_____ Insured Date of Birth_____ Insurance Company_____

Group # _____ Insurance Company phone # _____

Medical Health History

Name **Date of Birth** **Today's date**

Although dental personnel primarily treat the area in and around your mouth, your mouth is 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. Please answer 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 taken Phen-Fen or Redux? ___ Yes ___No If yes _____

Have you ever taken Fosamax, Boniva, Actonel or Any other medication containing bisphosphonates? ___ Yes ___No If yes _____

Are you on a special diet? ___ Yes ___No

Do you use tobacco? ___ 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 ____ Sulfa Drugs ____ Local Anesthetics

Other_____

Do you use controlled substances? ___ Yes ___ NO

Do you have, or have you had, any of the following? Please circle answer:

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
Arthritis/Gout	Yes	No	**Emphysema**	Yes	No	**High Blood Pressure**	Yes	No	**Rheumatism**	Yes	No
Artificial Heart Valve	Yes	No	**Epilepsy/Seizures**	Yes	No	**High Cholesterol**	Yes	No	**Scarlet Fever**	Yes	No
Artificial Joint	Yes	No	**Excessive Bleeding**	Yes	No	**Hives or Rash**	Yes	No	**Shingles**	Yes	No
Asthma	Yes	No	**Excessive Thirst**	Yes	No	**Hypoglycemia**	Yes	No	**Sickle Cell Disease**	Yes	No
Blood Disease	Yes	No	**Fainting/Dizziness**	Yes	No	**Irregular Heartbeat**	Yes	No	**Sinus Trouble**	Yes	No
Blood Transfusion	Yes	No	**Frequent Cough**	Yes	No	**Kidney Problems**	Yes	No	**Spina Bifida**	Yes	No
Breathing Problems	Yes	No	**Frequent Diarrhea**	Yes	No	**Leukemia**	Yes	No	**Stomach/Intestinal Disease**	Yes	No
Bruise Easily	Yes	No	**Frequent Headaches**	Yes	No	**Liver Disease**	Yes	No	**Stroke**	Yes	No
Cancer	Yes	No	**Genital Herpes**	Yes	No	**Low Blood Pressure**	Yes	No	**Swelling of Limbs**	Yes	No
Chemotherapy	Yes	No	**Glaucoma**	Yes	No	**Lung Disease**	Yes	No	**Thyroid Disease**	Yes	No
Chest Pains	Yes	No	**Hay Fever**	Yes	No	**Mitral Valve Prolapse**	Yes	No	**Tonsillitis**	Yes	No
Cold/Fever Sores	Yes	No	**Heart Attack/Failure**	Yes	No	**Osteoporosis**	Yes	No	**Tuberculosis**	Yes	No
Congenital Heart Disorder	Yes	No	**Heart Murmur**	Yes	No	**Pain in Jaw Joints**	Yes	No	**Tumors or Growths**	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 ____Yes ____No. If yes, 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 my medical status.

Signature of Patient, Parent or Guardian:

X_____ Date_____

GENERAL CONSENT FORM

Patient Name: _____ Date of Birth: _____ SSN: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

I do hereby authorize and request the performance of dental services Solace Dentistry may deem necessary for my treatment. I understand that Solace Dentistry will use clinical and patient management techniques that are reasonable, necessary, and advisable. I also authorize the administration of anesthetics or analgesics that may be deemed appropriate by Solace Dentistry. I understand that the purpose for using local anesthetics may be therapeutic, diagnostic, or for the treatment of facial pain. I understand that potential complications include but are not limited to pain, swelling, bruising, temporary limited opening, and local infection. I understand that in occasional cases the anesthesia may prolong and in very rare cases cause permanent numbness.

I understand that I am responsible for obtaining any current x-rays that may have been taken at a previous office.

I understand that any treatment plans presents, along with the fees outline, could change depending on the time elapsed since initial examination and extend of dental pathology. Occasionally, once the treatment plan has been started, complications may arise that dictate additional procedure or treatment. Solace Dentistry will always advise me of any changes. I understand my relevant personal health information may be released to my insurance company in order to get reimbursement.

In the event that Solace Dentistry is exposed to my blood or bodily fluids, I agree to have my blood drawn and tested for Hepatitis B, Hepatitis C, and the Human Immunodeficiency Virus. I understand that testing would be done in a confidential manner, and would be made available only to the person who was exposed, and that person would be advised of my rights regarding protected health information.

Patient Signature: _____ Date: _____

Signature of Parent, Guardian, or Personal Representative: _____
Relationship: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN.

FINANCIAL AGREEMENT

Thank you for choosing Solace Dentistry as your dental provider. Please understand that a financial agreement is an important part of the provider-patient relationship.

INSURANCE

We file insurance claims as a courtesy to you at no charge, and although we are on several Preferred Provider lists, **any insurance company can designate a procedure as "not covered".** The ultimate responsibility for payment for services is with you. When the Explanation of Benefits is received, our office will notify you by mail if your plan denied the procedures or paid less than we had anticipated. Once the annual maximum is reached, **you are fully responsible for ALL treatment completed.** Even a preauthorization of services does not guarantee payment from your insurance carrier. We have found that patients who are involved with their claims process are more successful at **receiving prompt and accurate** payment services from their insurance carrier. Please know that we will never alter nor compromise the way that we care for our patients or the treatment that we provide regardless of dental insurance coverage.

Patient Initial_____

DISCOUNTS

In-network patients who are receiving in-network fees are prohibited from receiving any additional discounts. A 5% discount only applies to out-of-network/non-insurance patients whose **treatment is paid in full by cash.**

Patient Initial_____

We accept cash, Visa, MasterCard, Discover, and AMEX. We also offer financing of treatment through CareCredit and for non-insured patients we offer Solace Connect.

I have read and understand the above financial agreement.

Signature_____ Date _____

RESERVATION AGREEMENT

We make every effort to value your time and we schedule your reservation just for you. We are committed to your oral health and keeping your reserved time allows us to be partners in your dental care.

We ask that you confirm your reservation a minimum of 2 business days prior. You may confirm via email, text message, or by calling our office during business hours. Failure to confirm your reservation may result in the loss of the time reserved for you and your treatment. Note we do not accept cancellations via answering machine.

Missed Reservation: Any reservation the patient does not keep or any reservation the patient cancels/changes within the 2 business days' notice.

We will not charge for your first missed reservation. However, there will be a $50.00 charge for a second missed reservation in a twelve month time span. At this time you will be required to pay ahead when scheduling your next reservation. If you keep the reservation the payment will be applied towards treatment. However, if you fail to keep the reservation the deposit will be forfeited.

It is our philosophy to continue to put our patients first and to make your experience a positive one. Thank you for allowing us to share our reservation policy with you. Please let us know if you have any questions.

Reservation Agreement

- I acknowledge an appointment is a reservation.
- I agree to provide a minimum of 2 business days' notice if I need to change my reservation for any reason.
- If I change my reservation without the required 2 business days' notice in a 12 month span, I acknowledge I may be asked to prepay at the time of scheduling in order to be appointed.
- I understand that I must confirm my reservation 2 business days prior to my reservation or forfeit the reservation made for me and any and all deposit.

Patient Signature: _____ Date: _____

AUTHORIZED FOR RELEASE OF INFORMATION

Name of Patient _____ Date of Birth_____

Solace Dentistry is authorized to release protected health information about the above named patient in the following manner and to persons listed.

***Information that may be communicated to you, authorized person/entity, other providers**: Appointment reminders, Treatment, Financial, Breach.

We may communicate to you via:(Circle all that apply) Voice mail Text message E-mail Answering Machine

*E-mail communication –Provide E-mail address: _____

*Text message communication- Provide cell phone number _____

**In order for e-mail/text communication to occur, please accept & initial the disclosure below:

Initial_____ Text/e-mail communication: I understand that if information is not sent in an encrypted manner, there is a risk it could be accessed inappropriately. It is my responsibility to update my email address. I still elect to more forward to allow email/text communication to occur.

Check each that can be given to person/entity listed below

___ Treatment/Out of Pocket
___ Appointment reminder
___ Breach notification

Choose all the Apply:

___Spouse ___Parent ___Step Parent ___Other, please specify:_____

Provide name and phone number: _____

Patient Rights:

- I have the right to revoke this authorization at any time
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be affective going forward.
- Information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

The information is released at the patient's request and this authorization will remain in effect until revoked by the patient.

_____ Date_____

Signature of Patient or Personal Representative

**Description of Personal Representative's Authority: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to Sign This Acknowledgement

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

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

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

____ Individual refused to sign
____ Communications barriers prohibited obtaining the acknowledgement
____ An emergency situation prevented us from obtaining acknowledgment
____ Other (Please Specify)