HOCKESSIN DENTAL
FAMILY & COSMETIC DENTISTRY

PATIENT REGISTRATION

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder
☐ 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: Trevor Scheff, DDS

Employer ID: Pref. Pharmacy:

Section 3

Referral Source::

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:

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:

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Patient Name:_____ DOB: _____ Date:_____

Are you under a physician's care or being treated for any type of condition?	○YES	○ NO	If yes
Are you taking medications, pills, drugs, or controlled substances?	○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
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	If yes
Do you use tobacco? If so, what frequency?	○YES	○ NO	If yes

Please check any that apply to you:

☐ Do you or your family members suffer from sleep apnea?

☐ Do you snore loudly (louder than talking or heard through closed doors)?

☐ Do you often feel tired, fatigued, or sleepy during the daytime?

☐ Has anyone observed you stop breathing during your sleep?

☐ Do you have or are you being treated for high blood pressure?

Women: Are you…

☐ Pregnant? ☐ Nursing? ☐ Taking oral contraceptives? ☐ Trying to get pregnant?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metals	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Other?	○ YES	○ NO	If yes

Are you satisfied with your smile? ○ YES ○ NO

What would you like to change about your smile?

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

ADD/ADHD	○ YES	○ NO	Heart Murmur	○ YES	○ NO
AIDS/HIV Positive	○ YES	○ NO	Heart Pacemaker	○ YES	○ NO
Alzheimer's Disease	○ YES	○ NO	Heart Trouble/Disease	○ YES	○ NO
Anaphylaxis	○ YES	○ NO	Hemophilia	○ YES	○ NO
Anemia	○ YES	○ NO	Hepatitis B	○ YES	○ NO
Angina	○ YES	○ NO	Hepatitis C	○ YES	○ NO
Anxiety	○ YES	○ NO	Herpes	○ YES	○ NO
Arthritis/Gout	○ YES	○ NO	High Blood Pressure	○ YES	○ NO
Artificial Heart Valve	○ YES	○ NO	High Cholesterol	○ YES	○ NO
Artificial Joint	○ YES	○ NO	Hives or Rash	○ YES	○ NO
Asthma	○ YES	○ NO	Hypoglycemia	○ YES	○ NO
Blood Disease	○ YES	○ NO	Irregular Heartbeat	○ YES	○ NO
Blood Transfusion	○ YES	○ NO	Kidney Problems	○ YES	○ NO
Breathing Problems	○ YES	○ NO	Liver Disease	○ YES	○ NO
Bruise Easily	○ YES	○ NO	Low Blood Pressure	○ YES	○ NO
Cancer	○ YES	○ NO	Lung Disease	○ YES	○ NO
Cerebral Palsy	○ YES	○ NO	Osteoporosis	○ YES	○ NO
Chemotherapy	○ YES	○ NO	Pain in Jaw Joints	○ YES	○ NO
Chest Pains	○ YES	○ NO	Parathyroid Disease	○ YES	○ NO
Cold Sores/Fever Blisters	○ YES	○ NO	Psychiatric Care	○ YES	○ NO
Congenital Heart Disorder	○ YES	○ NO	Renal Dialysis	○ YES	○ NO
Cortisone Medicine	○ YES	○ NO	Rheumatic Fever	○ YES	○ NO
Diabetes	○ YES	○ NO	Rheumatism	○ YES	○ NO
Drug Addiction	○ YES	○ NO	Shingles	○ YES	○ NO
Easily Winded	○ YES	○ NO	Sickle Cell Disease	○ YES	○ NO
Emphysema	○ YES	○ NO	Sinus Trouble	○ YES	○ NO
Epilepsy or Seizures	○ YES	○ NO	Stomach/Intestinal Disease	○ YES	○ NO
Excessive Bleeding	○ YES	○ NO	Stroke	○ YES	○ NO
Fainting Spells/Dizziness	○ YES	○ NO	Swelling of the Limbs	○ YES	○ NO
Frequent Cough	○ YES	○ NO	Thyroid Disease	○ YES	○ NO
Frequent Headache	○ YES	○ NO	Tonsillitis	○ YES	○ NO
Glaucoma	○ YES	○ NO	Tuberculosis	○ YES	○ NO
Growths	○ YES	○ NO	Tumors	○ YES	○ NO
Hay Fever	○ YES	○ NO	Ulcers	○ YES	○ NO
Heart Attack/Failure	○ YES	○ NO			

Have you ever had any serious illness not listed above?

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my (or the 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 _____

HOCKESSIN DENTAL
FAMILY & COSMETIC DENTISTRY
6300 Limestone Road Hockessin, DE 19707
302-239-7277 Fax 302-235-8598

Financial Policy

Thank you for choosing our office for your dental needs. We realize that every person's financial situation is different. For this reason, we have worked hard to provide a variety of payment options to help you receive the dental care you need and deserve that allows you to enjoy a healthy, beautiful smile with respect to your budget. Dental treatment is an excellent investment in an individual's medical and psychosocial care. We are always available to answer your questions or assist you in any way we can.

To maintain the practice operations and prevent potential misunderstandings, we ask patients to accept and adhere to the following arrangements regarding their dental treatment.

- **Patients without insurance coverage need to know...**
  The fee for the treatment rendered must be paid in full on the day of service.
- **Patients with dental insurance coverage need to know...**
  The ***estimated*** patient co-pay and deductible for the treatment rendered must be paid in full on the day of service. Please understand that you are ultimately responsible for all balances generated by your treatment.
- **We accept cash, check, debit cards, CareCredit, LendingClub and the following major credit cards: VISA, MasterCard, and Discover**

Payments:

Payment is expected at the time services are rendered unless arrangements have been made prior to the appointment. For patients wishing to make extended payments, we offer third-party financing through CareCredit and LendingClub. CareCredit and LendingClub allow low monthly payments for qualifying applicants. Unless we approve other arrangements the balance on your account is due and payable within 30 days after the balance is incurred.

Hockessin Dental does not send monthly statements or bills. A billing charge and finance charge will be applied if a statement needs to be sent to your home.

*A billing charge of $5.00 will be processed to your account if for any reason after 30 days we have to mail a statement to you. Any charges that are not paid within 90 days will incur a monthly financing fee of 1.5%.

We keep your credit card information securely on file; we will charge your credit card the balance of all charges not paid by the responsible party or your insurance company after a 90 day period. For our patients with insurance, after the submission of all forms, x-rays, and appropriate information to your insurance company on your behalf your card will be charged within 30 days of receiving an explanation of benefits. We will contact you via email or telephone call to inform you of any balance to your account. You are able to make different arrangements at that time with our financial coordinator if you do not wish to use the card left on file with us.

If you do not wish to leave your credit card number on file with us, you have the option to pay in full at the time of service and have your insurance company reimburse you directly. As a courtesy, we will submit all necessary forms to your insurance company on your behalf.

Returned Checks: There is a fee (currently $55) for any checks returned by the bank.

Insurance:
Insurance is a contract between you and your insurance company. We will bill your insurance company as a courtesy to you. Please note that services rendered on the assumption that the insurance company will pay us. You are ultimately responsible for payment and all balances generated by your treatment. If your insurance company has not paid your claim within ninety (90) days after the date of service, the full amount is due and payable by you. We will promptly refund to you any insurance payments we receive if you have already paid the balance on your account. It is your responsibility to inform us of any changes in your insurance coverage.

We ask you to provide the following information to facilitate your account processing:

Cardholder Name: _____

Card Type (circle one): ☐ VISA ☐ MasterCard ☐ Discover

Account Number: _____

Expiration Date: _____

Security Code (3 digits on the back of card):_____

Cardholder Signature_____

Email Address: _____

For patients WITH insurance:

I acknowledge that it is my responsibility to understand the terms of my dental coverage and to contact my insurance to get specific details on what my yearly allotment covers or does not cover. In addition I understand that I am responsible for the cost of treatment not covered by my insurance.

Insurance Release:
You authorize Hockessin Dental, P.A. to release any necessary information requested by your insurance carrier. I authorize payment directly to Hockessin Dental, P.A. and assign any benefits to Hockessin Dental, P.A.

Signature: _____ Date: _____

For ALL patients:

This is an agreement between Hockessin Dental, P.A. and the Patient named on this form. By executing this agreement, you consent to treatment by Hockessin Dental, P.A. and agree to pay for all services that are received. Once you have signed this agreement, you agree to all the terms and conditions contained herein and the agreement will be in full force and effect.

Patient Name: _____

Signature: _____ Date: _____

Effective: September 2015

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APPOINTMENT POLICY

The primary goal at Hockessin Dental is to provide excellent care in a timely manner. In order to reach those goals we have implemented an appointment policy that is both fair and respectful to all of our patients as well as our staff.

A specific amount of time is reserved especially for you, and we strongly encourage all patients to keep their appointments. We understand that life is busy, and things sometimes come up suddenly, all we ask is for common courtesy. We require **24 hours** notice if you need to reschedule your appointment. Evening appointments (later than 3pm) and treatment appointments for 2 hours or longer require **48 hours** notice if you need to reschedule. **If you know in advance that you cannot make your appointment while our office is closed you may call and leave a message, email or text us.**

Confirmation of appointments is a courtesy to our patients and allows both the patient and staff to address concerns the patient may have before the scheduled appointment time. We attempt to confirm all appointments 24 hours in advance during weekdays and on Thursdays for Monday appointments. **We ask that if you need to cancel an appointment for Monday that you notify the office by 3:00 pm on Thursday afternoon, otherwise you may be charged a cancellation fee.**

We understand that on occasion a situation may arise which causes you to be late. We will make all efforts towards completing your appointment on that same day if it does not complicate other scheduled patients and their appointments. If you arrive later than is feasible to complete your appointment, you will be rescheduled and it is considered a cancellation of less than 24 hours notice.

A minimum charge of $50 will be applied for appointments cancelled in less than 24 hours or failed appointments.

If you fail two appointments you may be required to pay a deposit to hold an appointment. You may also forfeit the ability to hold a future appointment in some cases and would be limited to our short call list. If you fail three appointments with less than 24 hours notice, you may be subjected to dismissal from the practice.

I have read and understand the appointment policy and realize that it is my responsibility to keep my appointments and arrive on time.

X_____ Date _____

Hockessin Dental

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.

Print Name: _____

Signature: _____

Date: _____

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:

- o __ Individual refused to sign
- o __ Communications barriers prohibited obtaining the acknowledgement
- o __An emergency situation prevented us from obtaining acknowledgement
- o __Other (Please Specify):

Patient Request for Confidential Communications

To the Patient: Use this form if you would like our dental practice to communicate with you other than your primary phone number, email addresses and/or mailing addresses. Fill out this request in its entirety.

Patient Name (print): _____

Alternative communication request (please tell us the way you would like us to communicate with you, and/or the address you would like us the use if different from your patient registration information):

_____

_____

Please indicate any family members/3rd parties that your health information may be shared if needed:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Payment Information:

Your request may affect our normal billing and payment procedure. Please specify your alternative method for handling payment. Typically payment is due at the time of treatment and any invoices or statements would b sent to your provided address and/or email address.

_____

_____

Signature of Patient: _____ **Date:** _____

For Personal Representatives of the Patient

Print Name: _____

Relationship to the patient: _____ Date: _____