PATIENT REGISTRATION

Date: _____
How did you hear about us? _____
Name of previous dentist: _____

PATIENT INFORMATION

First Name: _____ Last Name: _____ Middle Initial ____ Preferred Name: _____
Birth Date: ____/_____/_____ Age: ____ ◯ Male ◯ Female Soc Sec: ____-_____-_____
Address: _____ City, State, Zip: _____
Home Phone: _____ Work Phone: _____ EXT: _____ Cell Phone: _____
Email: _____◯ I would like to receive correspondences via e-mail
Emergency Contact: _____ Relationship: _____ Phone #: _____

ACCOUNT RESPONSIBLE PARTY INFORMATION OTHER THAN SELF

(Responsible Party must be at least 18)

Responsible Party Name: _____ Relationship to Patient: _____
Soc Sec: ____-____-_____ Birth Date: ____/_____/_____ ◯ Male ◯ Female
Address: _____ City, State, Zip: _____
Home Phone: _____ Work Phone: _____ EXT: _____ Cell Phone: _____
Alternate Phone:_____

PRIMARY INSURANCE INFORMATION

Insurance Company Name: _____
Ins. Phone #: _____ Employer: _____
Medicaid or Subscriber ID # _____
Policy Holder Name: _____
Birth Date: _____ Soc Sec: ____-____-_____
Relationship to patient: ___ Self ____ Spouse ____ Child

SECONDARY INSURANCE INFORMATION

Insurance Company Name: _____
Ins. Phone #: _____ Employer: _____
Medicaid or Subscriber ID # _____
Policy Holder Name: _____
Birth Date: _____ Soc Sec: ____-____-_____
Relationship to patient: ___ Self ____ Spouse ____ Child

Please tell us your chief dental complaints:

_____
_____
_____
_____
_____
_____

MEDICAL HISTORY FORM

PATIENT NAME: _____ BIRTH DATE: _____

Are you under a physician's care now? ◯ **Yes** ◯ **No** If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ◯**Yes** ◯**No If yes, please explain:** _____

_____

Have you ever had a serious head or neck injury? ◯ **Yes** ◯ **No** If yes, please explain: _____

Have you ever taken Fosamax, Boniva, Actonel or any other medication containing Bisphosphonates? ◯ **Yes** ◯ **No How Long? _____**

Are you currently taking Blood Thinner/Anticoagulants? ◯ **Yes** ◯ **No**

Do you require antibiotics before certain dental procedures due to having history of infective endocarditis, prosthetic cardias valves, and prosthetic joints? ◯ **Yes** ◯ **No**

Do you use tobacco? ◯ **Yes** ◯ **No** Do you use controlled substances/Alcohol? ◯ **Yes** ◯ **No**

Are you allergic to any of the following?

□ Aspirin □ Penicillin □ Codeine □ Local Anesthetics □ Acrylic □ Metal □ Latex □ Sulfa Drugs

□Other If yes, Please Explain: _____

Women Patients Only

Are you currently pregnant? ◯ Yes ◯ No Estimated Delivery Date: _____

Are you taking any birth control prescription? ◯ Yes ◯ No Are you Nursing? ◯ Yes ◯ No

PLEASE CHECK ANY CONDITION THAT APPLY TO YOU BELOW

AIDS/HIV Positive	◯ YES	Cortisone Medicine	◯YES	High Blood Pressure	◯YES	Sinus Problems	◯YES
Alzheimer's Disease	◯ YES	Diabetes	◯YES	High Cholesterol	◯ YES	Stroke	◯YES
Anaphylaxis	◯ YES	Drug Addiction	◯YES	Hives or Rash	◯ YES	Thyroid Disease	◯YES
Anemia	◯ YES	Easily Winded	◯YES	Hypoglycemia	◯ YES	Tuberculosis	◯YES
Angina	◯ YES	Emphysema	◯YES	Irregular Heartbeat	◯ YES	Ulcers	◯YES
Arthritis/Gout	◯ YES	Epilepsy	◯YES	Kidney Problems	◯YES	Visually Impaired	◯YES
Artificial Heart Valve	◯ YES	Excessive Bleeding	◯YES	Liver Disease	◯YES	Low Blood Pressure	◯YES
Artificial Joint/Pins	◯ YES	Fainting	◯YES	Herpes	◯YES	Shingles	◯YES
Asthma	◯ YES	Frequent Cough	◯YES	Lung Disease	◯YES	Seizure	◯ YES
Blood Disease	◯ YES	Genital Herpes	◯YES	Mitral Valve Prolapse	◯YES	Convulsions	◯ YES
Breathing Problem	◯ YES	Hay Fever	◯YES	Hepatitis B or C	◯YES	Osteoporosis	◯YES
Bruise Easily	◯ YES	Heart Attack	◯YES	Pain in Jaw Joints	◯YES	Rheumatic Fever	◯YES
Cancer	◯ YES	Heart Murmur	◯YES	Parathyroid Disease	◯YES	Psychiatric Care	◯YES
Chemotherapy	◯ YES	Heart Pacemaker	◯YES	Hepatitis A	◯YES	Radiation Treatment	◯ YES
Chest Pain	◯ YES	Congenital Heart Disorder	◯ YES	Heart Trouble	◯YES	Cold Sore/Fever Blister	◯ YES

Have you ever had any serious illness not listed above? ◯ **Yes** ◯ **No** **If yes, please explain:**

_____

***Please list any current medications and reasons:**

_____

_____

I affirm that the above information I have given is correct to the best of my knowledge. It will be held in confidence and it is my responsibility to inform this office of changes in the patient's medical status.

Patient Signature: _____ Print Name: _____ Date: _____

Appointment Agreement

We are honored that your family has entrusted Soft Heart Dentistry for your dental care. We strive to give each patient the individual attention they deserve. Therefore, we ask that you arrive on time for your appointment. If you arrive late to your appointment, we may need to reschedule your appointment. If we are able to see you, we cannot guarantee that all treatment will be completed. If a second appointment is missed, the patient may be dismissed from our practice, or required to make non-refundable deposit before scheduling another appointment.

Cancellation Policy

If you need to cancel or reschedule your appointment, we ask for a 24-hour notice of cancellation. If we do not receive a 24-hour notice, you will be charged a $40.00 fee for the scheduled appointment. This fee cannot be charged to your insurance company. You will be responsible for payment of the broken appointment fee. Broken appointment fee will need to be paid before scheduling an appointment.

If necessary, you may change your appointment two business days before the appointment.

We will call you 2 business days prior to your appointment to confirm. Appointments not confirmed will automatically be cancelled. We may also call you the day before your appointment to remind you of your appointment.

SATURDAY APPOINTMENT AGREEMENT

If you/patient **cancel, no show, or call on day of** Saturday appointment to reschedule, we will not be able to schedule you/patient another Saturday for a grace period of one month. Saturday appointment are high demand and we reserve the time slot for you/patient.

I acknowledge the appointment agreement above.

Signature: _____ Print Name: _____Date:_____

Relationship to patient: ◯ Self ◯ Parent ◯Legal Guardian

Insurance/Payment Policy

Welcome to Soft Heart Dentistry. We hope to make your appointment as pleasant as possible and ease your potential financial burden as much as possible. Please review our insurance and payment policies below to help you understand your financial responsibilities.

All deductible and fee amounts not covered by insurance are due at the time of service.

Insurance claims

Our office will file a claim for services rendered to your insurance. Services are rendered and charged to you, not your insurance company. Please understand that the contract is between you and the insurance company and payment for services is your responsibility.

If at the end of 45 days, your insurance company has not paid, you are responsible for the entire balance. Our office will not enter into dispute with your insurance company over your claim. Upon request, we will supply you with a copy of the claim.

Please be advised that you may be billed for services that your insurance company will not cover due to exclusions or plan limitations. At times, insurance may pay the composite (white) restoration at an alternate procedure, resulting in a possible balance for which you are responsible. Upon request a pre-treatment estimate can be sent to your insurance company.

Interest on late payments

Please pay all charges on time. We charge interest at the rate of 1 percent per month for charges not paid within 30 days. We recommend patients understand their insurance benefits and monitor their plans for prompt payment.

For your convenience, we accept cash, check, or credit cards (Visa, MasterCard, Discover, and American Express.) If you provide us with a check with insufficient funds or with a stop payment, you will be charged a $30.00 processing fee.

Collection costs

We will charge the patient's account for our collection costs if we refer the account to an outside agency or attorney for collection.

I have read and understand the insurance and payment policy above.

Signature: _____ Print Name:_____ Date:_____

Relationship to patient: ◯ Self ◯ Parent ◯Legal Guardian

CONSENT FOR INTERNET COMMUNICATIONS

I grant my permission to Soft Heart Dentistry to upload and store confidential patient information including account information, appointment information and clinical information to the secured website for Soft Heart Dentistry. I also understand State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand Soft Heart Dentistry will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my patient information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that Soft Heart Dentistry has the right to monitor, retrieve, store, upload and use my patient information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand Soft Heart Dentistry will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the website on my behalf. I understand Soft Heart Dentistry CAN NOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will respect the privacy of your health information. There are several circumstances in which we may have to use or disclose your health care information:

•We may have to disclose your health information to another health care provider or a hospital if it is necessary for our office to refer you to them for consultation or treatment.

•We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your service.

•We may need to use your personal information to remind you of your appointments.

I understand that all email communications in which I engage may be forwarded to other providers for the purposes of providing treatment to me. This may include but not be limited to sending your x-rays and/or minimal personal information to other providers via email. We strive to keep all patient information secure but unfortunately there is no assurance of confidentiality of information when communicating this way.

I have read and understand this policy and agree to the terms.

Signature: _____ Print Name:_____ Date:_____

Relationship to patient: ◯ Self ◯ Parent ◯Legal Guardian

Acknowledge Receipt of Privacy Practices

Patient name: _____ Date of Birth: _____

I have received either a paper or an electronic copy of the Notice of Privacy Practices for Soft Heart Dentistry. I understand that I am entitled to receive a paper copy of the Notice if I ask for it, even if I have already agreed to receive only an electronic copy.

Signature: _____ Print Name:_____ Date:_____

Relationship to patient: ◯ Self ◯ Parent ◯Legal Guardian