Perkins Dental Group

PATIENT REGISTRATION FORM

How did you hear about us? (Circle One)

Facebook Internet School Location

Friend/Family: _____ Other: _____

Patient Information

First Name: _____ Last Name: _____ Middle Initial: _____

Birth Date: _____ Social Security No: _____ Driver's License: _____

E-Mail: _____ ☐ I would like to receive correspondence via e-mail

Address: _____ Address 2: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ ☐ Receive text reminders Home Phone: _____ Work Phone: _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Patient/Guardian's Employer: _____ Emergency Contact 1: _____

Spouse/Guardian's Name: _____ Phone Number 1: _____

Student Status: _____ Emergency Contact 2: _____

Phone Number 2: _____

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Address 2: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cell Phone: _____

Birth Date: _____ Social Security: _____ Driver's License: _____

☐ Responsible Party is also Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Primary Insurance Information **If uninsured, leave blank.**

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: _____

MEDICAL HISTORY

Perkins Dental Group

Patient Name: _____ Birth Date: _____

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 interrelationship with the dentistry you receive. Thank you for asking the following questions

Are you under a physician's care now?	o Yes	o No	If yes, please explain: _____
Have you ever been hospitalized or had a major operation?	o Yes	o No	If yes, please explain: _____
Have you ever had a serious head or neck injury?	o Yes	o No	If yes, please explain: _____
Are you taking any medication, pills, or drugs?	o Yes	o No	If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux?	o Yes	o No	
Are you on a special diet?	o Yes	o No	
Do you use tobacco?	o Yes	o No	
Do you use controlled substances?	o Yes	o No	
Do you need to pre-medicate?	o Yes	o No	If yes, please explain: _____

Women: Are you pregnant/ trying to get pregnant? o Yes o No Taking oral contraceptives? o Yes o No Nursing? o Yes o No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other If yes, please explain: _____

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

AIDS/HIV Positive	o Yes	o No	Excessive Bleeding	o Yes	o No	Lung Disease	o Yes	o No
Alzheimer's Disease	o Yes	o No	Excessive Thirst	o Yes	o No	Mitral Valve Prolapse	o Yes	o No
Anaphylaxis	o Yes	o No	Fainting Spells/Dizziness	o Yes	o No	Pain in Jaw Joints	o Yes	o No
Anemia	o Yes	o No	Frequent Cough	o Yes	o No	Parathyroid Disease	o Yes	o No
Angina	o Yes	o No	Frequent Diarrhea	o Yes	o No	Psychiatric Care	o Yes	o No
Arthritis/Gout	o Yes	o No	Frequent Headaches	o Yes	o No	Radiation Treatments	o Yes	o No
Artificial Heart Valve	o Yes	o No	Genital Herpes	o Yes	o No	Recent Weight Loss	o Yes	o No
Artificial Joint	o Yes	o No	Glaucoma	o Yes	o No	Renal Dialysis	o Yes	o No
Asthma	o Yes	o No	Hay Fever	o Yes	o No	Rheumatic Fever	o Yes	o No
Blood Disease	o Yes	o No	Heart Attack/Failure	o Yes	o No	Rheumatism	o Yes	o No
Blood Transfusion	o Yes	o No	Heart Murmur	o Yes	o No	Scarlet Fever	o Yes	o No
Breathing Problem	o Yes	o No	Heart Pace Maker	o Yes	o No	Shingles	o Yes	o No
Bruise Easily	o Yes	o No	Heart Trouble/Disease	o Yes	o No	Sickle Cell Disease	o Yes	o No
Cancer	o Yes	o No	Hemophilia	o Yes	o No	Sinus Trouble	o Yes	o No
Chemotherapy	o Yes	o No	Hepatitis A	o Yes	o No	Spina Bifida	o Yes	o No
Chest Pains	o Yes	o No	Hepatitis B or C	o Yes	o No	Stomach/Intestinal Disease	o Yes	o No
Cold Sores/Fever Blisters	o Yes	o No	Herpes	o Yes	o No	Stroke	o Yes	o No
Congenital Heart Disorder	o Yes	o No	High Blood Pressure	o Yes	o No	Swelling of Limbs	o Yes	o No
Convulsions	o Yes	o No	Hives or Rash	o Yes	o No	Thyroid Disease	o Yes	o No
Cortisone Medicine	o Yes	o No	Hypoglycemia	o Yes	o No	Tonsillitis	o Yes	o No
Diabetes	o Yes	o No	Irregular Heartbeat	o Yes	o No	Tuberculosis	o Yes	o No
Drug Addition	o Yes	o No	Kidney Problems	o Yes	o No	Tumors or Growths	o Yes	o No
Easily Winded	o Yes	o No	Leukemia	o Yes	o No	Ulcers	o Yes	o No
Emphysema	o Yes	o No	Liver Disease	o Yes	o No	Venereal Disease	o Yes	o No
Epilepsy or Seizures	o Yes	o No	Low Blood Pressure	o Yes	o No	Yellow Jaundice	o Yes	o No

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

Do your gums bleed while brushing or flossing?	o Yes	o No	Has anyone said you stop breathing while you sleep?	o Yes	o No
Are your teeth sensitive to hot or cold liquid/foods?	o Yes	o No	Do you clench or grind your teeth?	o Yes	o No
Do you feel pain to any of your teeth?	o Yes	o No	Have you ever had any difficult extractions in the past?	o Yes	o No
Do you like your smile?	o Yes	o No			

If no, 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 medical status. By my signature below, I hereby consent to the examination and dental treatment. I understand dentistry is not an exact science and the results of any treatments vary from patient to patient. I understand occasionally, additional treatment may be required. I agree that cash payment or credit arrangements for the estimated un-insured portion of treatment will be made at the time of treatment and I agree that the estimate given to me may not be the final or exact amount that I will owe for treatment.

SIGNATURE OF PATIENT, PARENT or GUARDIAN _____ DATE: _____

Perkins Dental Group

FINANCIAL POLICY

We at Perkins Dental Group are proud to be part of a team whose primary mission is to deliver the finest and most comprehensive health care available today. In addition, we are also dedicated to making top-quality care as cost-effective as possible. To assist you with you healthcare investment, we provide the following payment options:

1. Cash – includes money orders and personal checks
2. Credit Card/ Debit Card – we accept all major credit cards as payment for your treatment.
3. CareCredit – the financing plan we offer as a separate line of credit to cover you and your family members' healthcare needs. With CareCredit you enjoy these benefits:
    a. Flexible financing options (plans with no interest and long-term plans with low interest)
    b. Credit decision usually only takes a few minutes
    c. No annual fees or prepayment penalties
    d. Ability to keep an open account and use at other healthcare offices

We are happy to provide you the above options to allow you to make convenient, low monthly payments. If CareCredit is your preferred option, you can begin any necessary treatment immediately and spread the payments out over time.

Patients that are not covered by insurance are expected to pay with cash, check, credit card, or use your CareCredit account the day the service is rendered.

☐ VIP Express Checkout – Please check this box for our new VIP Express Checkout option. Any cost under $200.00 will automatically be debited from your credit card on file and a receipt emailed to you.

Patients that are covered by insurance, we will honor the assignment of benefits. This means that the insurance company will pay their portion to our dental office. Most dental insurance plans do not cover 100% of the cost of treatment. Because of this, and the extreme delay in receiving payment from the insurance company, you will be asked to pay your deductible and your portion of the charges the day the service is rendered. We will estimate as closely as possibly your coverage, but until we actually receive the payment from the insurance company, it is just an estimate. The staff at Perkins Dental Group will assist you in dealing with your insurance company, but the ultimate responsibility lies with you. After 60 days, the balance will be due in full from you.

Feel free to ask questions that remain unanswered either before or after treatment. We are here to help you understand your treatment along with your benefits to help you make the right decisions about your dental health.

Signature _____ Date _____

Perkins Dental Group

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

NAME: _____ DATE OF BIRTH: _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of your Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

CONTACT PERSON: HIPAA Control Officer
TELEPHONE: 405-708-6644
E-MAIL: info@perkinsdentalgroup.com
ADDRESS: 150 E Hwy 33, Perkins, OK 74059

Right To Revoke: You will have the right to revoke this Consent at any time by giving us written notice of you revocation submitted to the Contact Person listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

_____ _____

Signature Date

ACKNOWLEDGMENT 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

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
- □ Communications barriers prohibited obtaining the acknowledgment
- □ An emergency situation prevented us from obtaining acknowledgment
- □ Other (Please Specify): _____