

Fairbanks Family Dental Care Inc.
John S. Brady

Patient Registration Form

Patient Name: _____ Preferred Name _____
SS#(Required for insurance): _____ License Number: _____
Mailing Address _____ City _____ State _____ Zip _____
Home Phone (____) _____ Mobile (____) _____
Email address: _____
DOB (Required for insurance): _____/_____/_____ Sex: Male___ Female___
Status: Married___ Single___ Other___
Spouse Name: _____ Phone Number: _____
Employer _____
Work Phone (____) _____
Work Physical Address _____
Emergency Contact Information
Name (last) _____ (first) _____ (mi) _____
Home Phone (____) _____ Mobile (____) _____ Work(____) _____

How did you hear about Fairbanks Family Dental Care Inc.?

Other Family members seen by us: _____

Parent/Guardian (if patient is a minor):

Name: _____ Relationship to Patient: _____
Home #: _____ Work #: _____
Address: _____ City: _____ State: _____ Zip: _____

Dental Insurance Information

Primary Insurance

Insurance Company Name _____ ID Number _____
Group Number _____
Subscriber Name _____ DOB _____ S.S _____
Relation to patient _____

Secondary Insurance

** Please let us know ahead of time which insurance is primary and which one is secondary**

Insurance Company Name _____ ID Number _____
Group Number _____
Subscriber Name _____ DOB _____ S.S _____
Relation to patient _____

Medical History

What is your general state of health? Excellent _____ Good _____ Fair _____ Poor _____
Have you been under constant care of a physician in the last year for an illness? Yes ___ No ___
If so, then why? _____
Physicians Name _____ Address/Phone Number _____
Have you had any major surgeries in the last 3 years? Yes _____ No _____
If so please elaborate _____

** If you need more space please elaborate on the back page **

Do you have any of the following? Check the box to all that apply

- AIDs
- Anemia
- Arthritis
- Artificial Joints
- Blood Disorder
- Cancer
- Diabetes
- Dizziness
- Tobacco Use
- Fainting
- Excessive Bleeding
- Glaucoma
- Hay Fever
- Head Injuries
- Heart Disease
- Heart Murmur
- Hep A, B, or C
- Recreational Drug
- High Blood Pressure
- Kidney Disease
- Liver Disease
- Mental Disorders
- Nervous Disorders
- Pacemaker
- Pregnant? Due Date _____
- Radiation Treatment
- Resp. Problems
- Rheumatic Fever
- Sinus problems
- Tuberculosis
- Venereal Disease
- Valve Replacement

Any other conditions, disease, or problem's not listed? _____

Drug Allergies:

- Latex
- Codeine
- Penicillin
- Erythromycin
- Dental Anesthetics
- Aspirin
- Tetracycline
- Other
- any not listed _____
- _____

Please list all medications you are taking, including over the counter drugs or herbs:

Medication:	Dosage:	Times/Day
_____	_____	_____
_____	_____	_____

Dental History:

Last dental visit: _____ Last Dental Cleaning: _____

Do you have any history of?

- Bleeding Gums
 - Broken/Chipped Fillings
 - Cavities
 - Food Traps
 - Loose Teeth
 - Missing Teeth
 - Periodontal/Gum Disease
 - Tender/Swollen Gums
 - Worn Teeth
 - Orthodontics
- If you answered yes, please elaborate below.

Do you have any of the following?

- Fixed Bridge
 - Full Denture
 - Loose/ Broken
 - Crowns
 - Implants
 - Removable Partial
- If so, are you comfortable with them? Yes _____ No _____

Consent for services

As a condition of treatment by this office, **all financial arrangements must be made in advance.** The practice depends upon collection from patients for the costs incurred for their care. An estimate of financial responsibility on the part of each patient will be determined before treatment.

All emergency dental services, or any dental services performed without previous arrangements, must be paid for at the time of service.

Any treatment recommendations are made based on what is best for you, our patient; treatment is not recommended based on what will or will not be covered by your insurance. As a courtesy, we will bill your insurance for services rendered. We will do our best to give you an accurate estimation for what will be paid by your dental insurance, but we cannot guarantee what they will pay. **It is our office policy to collect patient's estimated portion at the time of service. If your insurance does not pay because of a lack of benefits or for any other reason they see fit or they do not pay within 90 days the entire account balance will be due and payable by you. Fairbanks Family Dental Care will not be responsible for billing after that time.**

In consideration for the professional services rendered to me by the practice, I agree to pay the charges for the services at the time of treatment.

Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY.

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. The Notice takes effect April 14, 2002, and will remain until we replace it.

We reserve the right to change our privacy practices and terms of the Notice at any time, provided such changes are permitted by applicable law. We will change this Notice and make the new Notice available upon request. You may request a copy of your Notice at any time. You may contact us to request more information about our privacy practices.

USES AND DISCLOSURE OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. We may use or disclose your health information to a physician or other healthcare providers providing treatment to you. We may use or disclose your health information to obtain payment for services provided to you. We may use or disclose your health information with our healthcare operations. Healthcare operations include assessment and improvement activities, reviewing the competence or qualifications certification, licensing or credentialing activities.

Signature: _____ **Date:** _____

HIPAA COMPLIANCE:

In compliance with the Federal HIPAA policy we are requesting your permission to send out appointment reminders via postcards to the address on file. These postcards will have your name, address, time, and date of the appointment viewable by the post office.

Patient/Guardian Signature: _____ **Date:** _____

Financial Agreement

Please read entire form carefully, then sign and date the bottom.

The following define the financial policies of the practice.

Payment is due at the time services are rendered

The front desk staff will estimate the amount you owe for procedures the doctor or hygienist has completed or those procedures which are in progress. Remember, this is only an estimate. The actual out of pocket expense may be less than or greater than the amount estimated and collected. You may be reimbursed or apply the excess to another date of service if we have collected too much.

Some insurance plans require the patient to pay only a percentage or co-payment directly to our office. Some plans require the patient to pay the entire amount due for the visit and then reimburse the patient the covered amount. We will work with your plan, and submit the forms necessary to receive the reimbursement as a service to our patients.

Insurance Coverage

We accept many different insurance plans. All plans have a unique schedule of covered services depending on what plan you have or your employer purchased. There is no guarantee that services will be covered. You, or the person responsible for the account, will be responsible for payment of non-covered procedures. There may be additional charges to cover the costs of parts or lab fees, depending on the treatment provided and type of insurance coverage. If you wish, we can send a pre-determination to your insurance carrier. The advantage of this knowing approximately what your out of pocket expenses will be for the procedures. It is NOT a guarantee of payment. The pre-determination takes 4-6 weeks to process.

Major Work

Patients receiving major work, such as crowns, bridges, dentures or bleaching kits must have their portions completely paid off before the work can be delivered or cemented.

Cancellation Policy

Our time is as important as yours. We attempt to schedule as efficiently as possible to reduce waiting time. We ask that you the patient give us 24 hours' notice of cancellation.

Returned Checks

There will be a returned check fee for \$20 for any NSF checks. This fee may increase depending on the bank's charges. The fee will be added to the outstanding balance.

I understand the financial policies of Fairbanks Family Dental Care and agree to them.

Signature of Responsible Party

Date