PATIENT REGISTRATION

First Name: _____Last Name: _____Middle Initial: _____

Preferred Name: _____

Patient is : □ Responsible Party □ Policy Holder

Responsible Party: (if someone other than the patient)

First Name: _____Last Name: _____Middle Initial: _____

Address: _____ Address 2: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____Cell Phone: _____

Birth date: _____Social Security #: _____Drivers Lic#: _____

○ Responsible Party is Policy Holder for Patient ○ Primary Policy Holder ○ Secondary Policy Holder

Patient Information:

Address: _____Address 2: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____Cell Phone: _____

Sex: ○ Female ○ Male Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth date: _____Social Security #: _____Drivers Lic#: _____

E-mail: _____ □ I would like to receive email correspondences

Primary Insurance Information:

Name of Insured: _____ Relationship to Insured: ○Self ○Spouse ○Child ○ Other

Insured Social Security #: _____ Insured Birth date: _____

Employer: _____Insurance 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 Social Security #: _____ Insured Birth date: _____

Employer: _____Insurance Company: _____

Address: _____ Address: _____

Address 2: _____Address 2: _____

City, State, Zip: _____City, State, Zip: _____

MEDICAL HISTORY

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 important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

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: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ 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: _____

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

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

Comments: _____

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.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

DENTAL HISTORY

What are your primary concerns about your teeth and oral health? _____
_____

Former Dentist_____ Phone Number _____
Address_____
Date of last dental care? _____ Date of last x-rays_____

Circle if you have had problems with any of the following:

Bad breath	Sensitivity to hot or cold	Food collecting in teeth
Bleeding gums	Sensitivity to sweets	Periodontal treatment
Loose teeth or broken fillings	Sensitivity when biting	Sores or growths in mouth
Grinding or clenching teeth	Clicking jaw or jaw pain	Problems Chewing

How often do you brush? _____ How often do you Floss? _____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? [] Y [] N

Any other important information about your dental health or previous treatment _____

A referral from your friends and/or family is a great reward!

Whom may we thank for referring you to or office? _____

(Please circle one answer for each question)

1. A) My mouth is very comfortable.
   B) My mouth is moderately comfortable.
   C) My mouth is uncomfortable.

2. A) I think the appearance of my smile is excellent.
   B) I am satisfied with the appearance of my smile.
   C) I would like to change my smile.
   D) I am unconcerned about the appearance.

3. A) I will do whatever I must to keep my teeth.
   B) I want to keep my teeth but only within a certain budget of time and money.
   C) I am indifferent about keeping my teeth.

4. A) I have always done what was recommended for my dental health.
   B) I have not always done what dentists have recommended for my mouth.
   C) I have not had dentistry recommended to me.

5. A) I put dental care high on my list for myself.
   B) I put dental care low on my list.
   C) I have never considered where I put dental care.

6. A) I think my present state of dental health is excellent.
   B) I think my present state of dental health is good.
   C) I think my present state of dental health is poor.

Obstacles I see to having excellent dental care for myself....
If you select more than one of the following please number them in order of significance with #1 being that which is most significant for you at this time.

____ I see no obstacles
____ Time away from work or other obligations
____ Fear of pain, surgery, injections
____ Fear of past dental experiences
____ The cost of treatment
____ Other _____

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OUR FINANCIAL POLICY

Thank you for choosing us as your dental health care provider. Please understand that payment of your bill is considered a part of your treatment. Please read the following information and sign below that you understand and agree to the following terms.

REGARDING PAYMENT AND INSURANCE

We will accept assignment of insurance benefits if you have dental insurance coverage. As a courtesy, we will file your dental claim to your dental benefit carrier for payment of their portion of your fee. We do require that you pay your estimated portion when services are rendered unless other financial arrangements have been made. Please provide us with complete data on your dental benefit provider and present any new dental cards to the receptionist upon arrival to our office. Your benefit policy is a contract between you and your dental benefit provider. Any balance on your account is ultimately your responsibility should your dental benefit provider refuse payment for any reason. We will facilitate the claims process by filing claims for you. If your insurance carrier has not paid your claim in full within 45 days of treatment, you will be responsible for any balance at that time and will need to request that your insurance carrier send their payment (if any) directly to you. Please be aware that some of the services we provide may be considered non-covered services and not considered reasonable and necessary under your dental benefit provider guidelines. You will be responsible for payment of procedures not covered by the insurance company when procedures are denied for pre-existing, missing tooth clauses, replacement clauses or alternative benefits, or if your annual maximum has been reached. We will file preauthorization of procedures upon your request. However, preauthorization is not a guarantee of payment by your insurance company. Any balance more than 45 days overdue will be subject to a 1.5% monthly finance charge (18% annually) as well as any fees incurred in the event that your account must be transferred to a collection agency.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best possible treatment for our patients. Our fees are usual and customary for our area. You are responsible for payment regardless of the dental benefit carrier's determination of usual and customary rates.

SCHEDULED AND MISSED APPOINTMENTS

Dr. Remigailo and his staff reserve your appointment time exclusively for you. We will be here fully prepared to serve you and we request that when you put your name in our appointment book that it represents a statement of your commitment to be here. ***Because we are committed to keeping our fees as affordable as possible for all of our patients we are unable to honor short notice appointment changes (except for an emergency).*** This indicates we have a mutual respect for each other's time. Please be advised that any appointment cancelled with less than 48 hours notice will be subject to a **$75 cancellation fee**. As a courtesy, we will contact you 2 days in advance to remind you of your appointment(s). Please make every attempt to keep your originally scheduled appointment. If you have any question about an appointment, please call to confirm to avoid any potential problems.

Please let us know if you have any questions or concerns.

Signature (patient or guardian)_____ **Date** _____

Richard Remigailo Jr, DMD, LLC

HIPAA CONSENT FORM

Patient Name _____

Consent for Release of Medical and Financial Information

____ Self Only ___ Authorized Individual(s)

Name	Phone Number	Relationship
_____	_____	_____
Name	Phone Number	Relationship
_____	_____	_____

In the event we are unable to reach you or your authorized individual(s), may we leave a detailed message with your results on an answering machine or voicemail at the above listed telephone number?

____ yes ____ no

Ok to receive an email?

____ yes ____ no

Ok to receive text messages?

____ yes ____ no

Signed by Patient (or Parent/Guardian, if patient is a Minor) _____