PATIENT REGISTRATION

PATIENT INFORMATION

Patient's Name: ____ Date: __________
Last, First MI (Preferred Name)

Address: ____
Street Apartment #

____
City State Zip Code

Email: ________________________ **Gender:** ☐ Male ☐ Female **Family Status**: ☐ Single ☐ Married ☐ Child

Social Security #: ________________ **Birth Date**: ________________________

Drivers License # __________________________ *Office Use only: Copy in file? ☐ Yes ☐ No*

****HIPPA****: *Do we have permission to leave appointment, billing or dental information on your answering machine, voicemail or e-mail at the following numbers ? Please check "Yes" or "No" for each contact number.*

Home Phone: ____________ ☐ Yes ☐ No Best time to call: __________
Work Phone: ____________ Ext:______ ☐ Yes ☐ No Best time to call: __________
Cell Phone: ____________ ☐ Yes ☐ No Best time to call: __________
Cell Text Message: ____________ ☐ Yes ☐ No
E-mail: ________________________ ☐ Yes ☐ No
Pager: ____________ ☐ Yes ☐ No
Fax: ____________ ☐ Yes ☐ No

Employer: ______________________________ **Occupation**: ____________________

Employer Address: ____
Street City, State Zip Code Phone

In case of an emergency, contact: ____________________ Phone ________________________

RESPONSIBLE PARTY/GUARANTOR INFORMATION

Only if the person responsible for this account is NOT the patient, complete the following information for the Guarantor:

Guarantor Name: ____
Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other ________________
Gender: ☐ Male ☐ Female **Family Status**: ☐ Married ☐ Single ☐ Divorced ☐ Child ☐ Other ______________

Address: ____
Street City State Zip Code

Social Security #: ________________________ Birth **Date:** ____________________
Drivers License # __________________________ *Office Use only: Copy in file? ☐ Yes ☐ No*

Phone Numbers: Home: ____________ Work: ____________ Ext: ______ Pager: ____________
Cell: ____________ Fax: ____________ E-mail: ________________________

Employer Name: __________________________ **Occupation:** ____________________

Employers Address: ____
Street City State Zip Code Phone

REFERRAL INFORMATION

How did you learn about, or who referred you to, our dental office? ☐ Patient/friend ☐ Our Staff, ☐ Another Dental Office, ☐ Yellow Pages, ☐ Insurance Plan, ☐ Newspaper, ☐ TV, ☐ Website, ☐ Newsletter, ☐ School, ☐ Your employer
☐ Direct Mail Postcard ☐ Other ____________________________

Name of person or dental or medical office who referred you: ______________________________

INSURANCE INFORMATION

Primary Insurance

Name of Primary Subscriber/Insured: ______________________ (Last / First / MI) Is the insured a patient? ☐ Yes ☐ No

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other ____________

Insured's Social Security # ____________ Birth Date: ____________ Date Employed ____________

Insured's Address: ______________________ (Street / City / State / Zip Code)

Insured's Employer Name: ______________________ Work Phone: ____________ Ext ______

Address: ______________________ (Street / City / State / Zip Code)

Insurance Carrier/Plan Name: ____________ Insurance Group #: ______ Insurance ID#: ______

Insurance Company Address: ______________________ (Street / City / State / Zip Code / Phone)

Medical Insurance

Name of Primary Subscriber/Insured: ______________________ (Last / First / MI) Is the insured a patient? ☐ Yes ☐ No

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Legal Guardian ☐ Other ____________

Insured's Social Security # ____________ Birth Date: ____________ Date Employed ____________

Insured's Address: ______________________ (Street / City / State / Zip Code)

Insured's Employer Name: ______________________ Work Phone: ____________ Ext ______

Address: ______________________ (Street / City / State / Zip Code)

Insurance Carrier/Plan Name: ____________ Insurance Group #: ______ Insurance ID#: ______

Insurance Company Address: ______________________ (Street / City / State / Zip Code / Phone)

PATIENT'S HEALTH INFORMATION

Date of Last Dental Visit: ____________ Reason for this visit: ______________________

Have you ever had any of the following health problems, conditions or habits?

Y N

☐ ☐ AIDS
☐ ☐ Allergy (Codeine)
☐ ☐ Allergy (Penicillin)
☐ ☐ Allergy Other ______
☐ ☐ Anemia
☐ ☐ Arthritis, Rheumatism
☐ ☐ Artificial Heart Valves
☐ ☐ Artificial Joints, Pins...
☐ ☐ Asthma
☐ ☐ Back Problems
☐ ☐ Bleeding Abnormally
☐ ☐ Blood Disease
☐ ☐ Cancer
☐ ☐ Chemical Dependency
☐ ☐ Chemotherapy
☐ ☐ Circulatory Problems
☐ ☐ Congenital Heart Defect
☐ ☐ Cortisone Treatments
☐ ☐ Cough, Persistent

Y N

☐ ☐ Cough up blood
☐ ☐ Diabetes
☐ ☐ Dizziness
☐ ☐ Epilepsy
☐ ☐ Excessive Bleeding
☐ ☐ Fainting
☐ ☐ Glaucoma
☐ ☐ Growths
☐ ☐ Hay Fever
☐ ☐ Headaches
☐ ☐ Head Injuries
☐ ☐ Heart Disease
☐ ☐ Heart Murmur
☐ ☐ Hemophilia
☐ ☐ Hepatitis
☐ ☐ Hernia Repair
☐ ☐ High Blood Pressure
☐ ☐ Jaundice
☐ ☐ Jaw Pain

Y N

☐ ☐ Kidney Disease
☐ ☐ Liver Disease
☐ ☐ Mental Disorders
☐ ☐ Mitral Valve Prolapse
☐ ☐ Nervous Disorders
☐ ☐ Pacemaker
☐ ☐ **Pregnancy**
Due date:______
☐ ☐ Radiation Treatment
☐ ☐ Respiratory Problems
☐ ☐ Rheumatic Fever
☐ ☐ Rheumatism
☐ ☐ Scarlet Fever
☐ ☐ Sexually transmitted disease (including HIV/AIDS)
☐ ☐ Shortness of Breath
☐ ☐ Sinus Problems
☐ ☐ Skin rash
☐ ☐ Smoking __/day __/year

Y N

☐ ☐ Stomach Problems
☐ ☐ Stroke
☐ ☐ Swelling of feet/ankles
☐ ☐ Substance Abuse
☐ ☐ Thyroid Problems
☐ ☐ Tobacco Habit
☐ ☐ Tonsillitis
☐ ☐ Tuberculosis
☐ ☐ Tumors
☐ ☐ Ulcers
☐ ☐ Venereal Disease
☐ ☐ Other:

Have you ever had any of the following dental problems or conditions? Please check those that apply:

Y N

☐ ☐ Bad Breath
☐ ☐ Bad Taste
☐ ☐ Bleeding Gums
☐ ☐ Clicking/popping of jaw
☐ ☐ Food caught in teeth

Y N

☐ ☐ Grinding or clenching teeth
☐ ☐ Loose teeth
☐ ☐ Broken Fillings
☐ ☐ Periodontal treatment
☐ ☐ Sensitivity to cold

Y N

☐ ☐ Sensitivity to sweets
☐ ☐ Sensitivity to hot
☐ ☐ Sensitivity when biting
☐ ☐ Sores/growth in the mouth
☐ ☐ Local Anesthetic-Novocain

Y N

☐ ☐ Nitrous Oxide
☐ ☐ Prolonged bleeding
☐ ☐ General Anesthetic
☐ ☐ Extractions
☐ ☐ Braces

Please answer the following dental/medical questions:

- Have you ever been, or do you need to be, pre-medicated for dental work? ☐ Yes ☐ No
- How often do you floss? ______________________

- Have you ever worn dentures or partials? ☐ Yes ☐ No If so, how old are they? ____________________
- Do you want whiter teeth? ☐ Yes ☐ No
- Do you want straighter teeth? ☐ Yes ☐ No
- Do you chew on one side? ☐ Yes ☐ No
- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: ____________________
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: ____________________
- Are you pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No
- Are you taking birth control pills? ☐ Yes ☐ No
- **Are you now under the care of a physician?** ☐ Yes ☐ No
  If yes, please explain: ____________________
- **Name of Physician:** ____________________ **Phone:** ____________
- **Do you have any health problems that need further clarification**? ☐ Yes ☐ No
  If yes, please explain: ____________________
- **Please list ALL MEDICATIONS currently being taken and the related diagnosis or medical condition:**

____

Elan Salee D.M.D., P.A. (DBA: Boynton Dental Studio) TERMS AND CONDITIONS OF SERVICE

In consideration of all services provided by **Elan Salee D.M.D., P.A. (DBA: Boynton Dental Studio)** and its employees, contractors and/or affiliates, the undersigned hereby acknowledges and agrees (on behalf of himself or herself and his or her children, dependents and other persons for whom he or she serves as guarantor (collectively, "Dependents") with the following terms and conditions of service:

Medical Information. The undersigned hereby certifies that all information provided to Elan Salee D.M.D., P.A. is true, correct and complete and agrees to promptly inform Elan Salee D.M.D., P.A. of any changes in any information (including regarding any Dependent). Elan Salee D.M.D., P.A. is authorized to use and disclose to any insurance, billing, management or processing company, agency or organization any health care information/medical records relating to the undersigned or any Dependent to obtain payment for services, determine insurance benefits or otherwise as required by law. Elan Salee D.M.D., P.A. is authorized to contact the undersigned at any telephone number provided above (unless otherwise revoked in writing) to discuss this form and any billing, treatment, or other matter related to any dental treatment (including for any Dependent).

Treatment; Informed Consent. The undersigned authorizes Elan Salee D.M.D., P.A. and any treating dentist, hygienist and/or staff to perform all treatment described in any treatment plan (and including all other services determined by such dentist to be necessary or appropriate in connection with such treatment plan) accepted by undersigned for himself/herself or any dependent. Dentistry is a biological procedure and not an exact science; therefore, despite the highest standard of care, no guarantee is or can be given by Elan Salee D.M.D., P.A. or any dentist or any other person employed or contracted by Elan Salee D.M.D., P.A. regarding any treatment or the results that may be obtained. The patient must comply with all specified appointments, procedures and continuing care and failure to do so will adversely affect the patient's treatment often necessitating additional required treatment (or retreatment) with additional fees. Failure to show within 15 minutes of the scheduled time for, or provide at least 48 hours advance notice of cancellation of, any appointment for any reason will result in a broken appointment fee. Elan Salee D.M.D., P.A. does not exercise control over the professional services of any of its treating dentists; therefore, the undersigned shall solely hold the treating dentist responsible for any treatment performed (including, without limitation, treatment provided under the treating dentist's supervision) and agrees to hold Elan Salee D.M.D.,P.A. and its officers, directors, owners and affiliates harmless from any claim, suit, loss or damage related to any dental treatment. Fees in treatment plans for non-insurance/discount plan patients are only valid for 30 days; all insurance/discount plan fees are subject to change at any time based upon changes in plan fee schedules or to correct errors.

Financial Responsibility; Insurance. **THE UNDERSIGNED PATIENT AND/OR GUARANTOR ASSUME FULL RESPONSIBILITY FOR PAYMENT OF ALL FEES AND CHARGES FOR ALL SERVICES OF Elan Salee D.M.D., P.A. (DBA: Boynton Dental Studio), WHETHER OR NOT COVERED BY INSURANCE. THE PATIENT'S PORTION OF ALL FEES (INCLUDING ALL DEDUCTIBLES AND CO-PAYS) IS DUE AND PAYABLE IN FULL AT THE TIME SERVICES ARE PERFORMED** (for treatment involving multiple appointments, such as a crown, root canal, denture or implant, the entire patient portion is normally due when treatment is started). Any special financial arrangements must be made before treatment is started. All insurance, discount plans and discount coupons must be presented before treatment is started. Elan Salee D.M.D., P.A. submits insurance claims solely to primary dental insurance for patients' convenience and does not assume responsibility for the processing of such insurance or failure of insurance to pay for any reason. **Dental insurance rarely covers all fees; estimated or preauthorized insurance benefits are not guaranteed.** The undersigned agrees to promptly pay on demand any balance not paid by insurance within 60 days after the date of service. A service charge of 1½% per month (18% per annum) is charged on all balances more than 30 days past due. Insurance balances are considered past due if not paid within 60 days of the date of service. The undersigned shall pay all costs incurred by Elan Salee D.M.D.,P.A. relating to collection of any unpaid or delinquent balance (including, without limitation, attorneys and collection agency fees, court costs, paralegals) whether or not suit is filed. Elan Salee D.M.D., P.A. reserves the right to terminate or deny any treatment if the patient's account is delinquent.

Assignment of Benefits; Authorization and Release. The undersigned hereby certifies that all insurance coverage described above is current and valid and assigns directly to Elan Salee D.M.D., P.A. all insurance benefits covering the undersigned or any Dependent for all services rendered. The undersigned hereby agrees that his/her signature below will be maintained "on file"; Elan Salee D.M.D., P.A. (DBA: Boynton Dental Studio) is authorized to use such signature on all applicable insurance claims and submissions. If any insurance payment is made to the undersigned, he/she shall immediately remit such payment to Elan Salee D.M.D., P.A.

Notice of Privacy Practices. The undersigned has reviewed a copy of Elan Salee D.M.D., P.A. (DBA: Boynton Dental Studio) Notice of Privacy Practices effective April 14, 2003, as amended.

I have read the above terms and conditions of service by Elan Salee D.M.D., P.A. (DBA: Boynton Dental Studio) and understand and accept such terms:

____________________ Date: ____________ Witness: ____________________
Signature of Patient

____________________ Date: ____________ Relationship to Patient: ____________________
Signature of Responsible Party/ Guarantor (For minors, parent or legal guardian must sign)

HIPAA COMPLIANCE FORM

Patient Consent to Receive Mail and/or Telephone Messages

Patient's Name: (*Please print*)

____

LAST NAME FIRST NAME MIDDLE

1. Do we have your permission to send recall/treatment appointment reminders to your home? Yes____ No ____

2. Do we have your permission to leave the following information on your home answering machine or voice mail?

Appointment Information	Yes ____	No ____
Billing Information	Yes ____	No ____
Dental/Medical Information	Yes ____	No ____

3. Do we have your permission to leave the following information on your work answering machine or voice mail?

Appointment Information	Yes ____	No ____
Billing Information	Yes ____	No ____
Dental/Medical Information	Yes ____	No ____

4. Do we have your permission to send the following information to your e-mail address provided to us on your patient registration form?

Appointment Information	Yes ____	No ____
Billing Information	Yes ____	No ____
Dental/Medical Information	Yes ____	No ____

5. Do we have your permission to send the following information to your cell phone number (including text messages) provided to us on your patient registration form?

Appointment Information	Yes ____	No ____
Billing Information	Yes ____	No ____
Dental/Medical Information	Yes ____	No ____

6. Do we have your permission to send the following information to your fax machine at the number provided to us on your patient registration form?

Appointment Information	Yes ____	No ____
Billing Information	Yes ____	No ____
Dental/Medical Information	Yes ____	No ____

7. I hereby give permission to share any information concerning me with the person(s) named below:

Name: ______________________________ Name: ______________________________

DATE: ________________________

SIGNED: ________________________________ **WITNESS:** ________________________________

Print Name: ________________________________ Print Name: ________________________________