# Patient Registration

## Personal Information

Name _____ Wish to be called _____

Birth Date _____/_____/_____ Driver's License # _____

Address _____ City _____

State _____ Zip _____ Home Phone # _(_____)_____

Cell Phone # _(_____)_____ Work Phone # _(_____)_____

Which Phone # do you prefer to receive calls? _____

College Student Status o Full Time o Part Time College Name: _____

o Female o Male

o Minor (under 18) o Single o Married o Separated o Divorced o Widowed

Emergency Contact Name _____ Emergency Contact # _(____)_____

I would like to receive appointment reminders via e-mail: E-mail Address _____

How did you learn about Bruce Merry DDS? _____

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## Responsible Party (Who is responsible for payment of your dental services?)

o Self o Parent o Other

Name of Responsible Party (if other than Self) _____

Responsible Party's (if other than Self) Home Phone # (___)_____ Cell Phone # (___)_____

Address (if different from Self) _____

City _____ State _____ Zip _____

Responsible Party's Employer _____ Work Phone # _(____)_____

(See Back Page)

# Dental Insurance Information

Note: Please be careful to submit a DENTAL insurance card, NOT your health/medical insurance card. Also note, we CANNOT process your dental insurance without the following information:

## Who is the Primary Dental Insurance Policyholder?

o Self o Spouse o Parent o Other

Policyholder's name (if other than Self) _____

Policyholder's Address (if other than Self) _____

City _____ State _____ Zip _____

Policyholder's Employer _____ Work Phone # _(____)_____

Home Phone # _(_____)_____ Cell Phone # _(_____)_____

Policyholder's Birth Date (if other than self) _____/_____/_____ (very important!)

Dental Insurance Policy/Subscriber/Member ID # _____

If above ID # is unknown, please give Policyholder's SS # _____ (very important!)

Name of Dental Insurance company _____ Group/Plan # _____

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## Secondary Dental Insurance

Policyholder's Name _____ Policyholder's Address _____

Policyholder's Employer _____ Phone # _(____)_____

Policyholder's Birth Date _____/_____/_____

Dental Insurance Policy/Subscriber/Member ID/SS # _____

Name of Dental Insurance company _____ Group/Plan # _____

# Medical/Dental History

**Name** _____ **Birth date** _____

**Name of Primary Care Physician** _____

Last dental appt? _____ Any negative dental experiences? _____

Have you ever had a serious head or neck injury? O YES O NO If yes, please explain _____

Are you taking any medications, pills, or drugs? O YES O NO If yes, please list _____

_____

Do you, or have you taken, Phen-Fen or Redux? O YES O NO Do you use tobacco? O YES O NO

Are you pregnant? O YES O NO Taking oral contraceptives? O YES O NO Nursing? O YES O NO

Have you ever been instructed by a doctor to take an antibiotic (pre-medicate) prior to dental appointments? O YES O NO

**Are you allergic to any of the following?**

O Aspirin O Penicillin O Codeine O Acrylic O Metal O Latex O Local Anesthetics O Other _____

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

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| AIDS/HIV Positive | O YES | O NO | Congenital Heart Disorder | O YES | O NO | Kidney Problems | O YES | O NO |
| Alzheimer's Disease | O YES | O NO | Diabetes | O YES | O NO | Leukemia | O YES | O NO |
| Anaphylaxis | O YES | O NO | Epilepsy or Seizures | O YES | O NO | Liver Disease | O YES | O NO |
| Anemia | O YES | O NO | Excessive Bleeding | O YES | O NO | Mitral Valve Prolapse | O YES | O NO |
| Angina/Chest Pains | O YES | O NO | Frequent Headaches | O YES | O NO | Pain in Jaw Joints | O YES | O NO |
| Arthritis/Gout | O YES | O NO | Glaucoma | O YES | O NO | Radiation Treatments | O YES | O NO |
| Artificial Heart Valve | O YES | O NO | Heart Attack/Failure | O YES | O NO | Rheumatic Fever | O YES | O NO |
| Artificial Joint | O YES | O NO | Heart Murmur | O YES | O NO | Scarlet Fever | O YES | O NO |
| Asthma | O YES | O NO | Heart Pace Maker | O YES | O NO | Shingles | O YES | O NO |
| Blood Disease | O YES | O NO | Heart Trouble/Disease | O YES | O NO | Sinus Trouble | O YES | O NO |
| Blood Transfusion | O YES | O NO | Hemophilia | O YES | O NO | Stomach/Intestinal Disease | O YES | O NO |
| Bruise Easily | O YES | O NO | Hepatitis B or C | O YES | O NO | Stroke | O YES | O NO |
| Cancer | O YES | O NO | Herpes | O YES | O NO | Tuberculosis | O YES | O NO |
| Chemotherapy | O YES | O NO | High Blood Pressure | O YES | O NO | Tumors or Growths | O YES | O NO |
| Cold Sores/Fever Blisters | O YES | O NO | Hypoglycemia | O YES | O NO | Ulcers | O YES | O NO |

**Have you ever had any serious illness or operation not listed above?** O YES O 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 for 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 _____

brucemerrydds

**As your dental provider, we are required under HIPAA (Health Insurance Portability and Accountability Act) to maintain the privacy of your health information and dental records. We may disclose this information to process your insurance claims, collect payment on your account, and consult with outside providers associated with your treatment. You have the right to restrict how your private information is disclosed if done so in writing.**

**With my signature, I acknowledge that I can review the Notice of Privacy Practices which provides greater detail of the uses of my private health information. I have the right to obtain a copy of the Notice of Privacy Practices at any time.**

**Patient (or representative) Signature** _____

**Patient Name (printed)** _____ **Date** _____

**I hereby give permission to the office of Bruce Merry DDS to share medical information with a family member or friend who assists in my care, either financially or medically. (We will only give out necessary information to the following individuals as it pertains to your dental care.)**

☐ **Please Initial**

**I only want to release information to the following individual(s):** _____

# Financial Agreement

Our desire in serving as your dental provider is open, honest communication and nowhere is that more important than in the area of finances. This agreement is designed to inform you of our expectations in paying for your treatment. Please read it and ask any questions that pertain to these policies.

**Payment Policy:**

- Non-insurance payments are expected at the time of service.
- We accept cash, personal checks, Visa, MasterCard, and Discover.
- We also offer third party financing for patients known as CareCredit.
- Accounts are due and payable in full 60 days following the date of service. Accounts not paid in 60 days will be subject to a finance charge of 1.5% per month on the unpaid balance.

**Dental Insurance:** We will submit your claims providing you agree to the following -

- You must provide us with a **dental** insurance card that is current and contains the necessary information for claim submission.
- Your insurance policy is a contract between you and your insurance company. We are ***not*** part of that contract. Our relationship is with you and not your insurance company.
- You are responsible for charges not paid by your insurance company and our estimates are made without knowledge of your insurance plan limitations, exclusions, etc.
- Charges not covered by your insurance company are your responsibility. Fees for non-covered services, along with deductibles and copayments, are due at the time of service.

**Cancelled or Missed Appointments:**

- Please provide us with a 24 hour (Business Day) notice if you intend to cancel your appointment. Missed appointments or cancellations made without 24 hour notice are charged at $50 on the third occurrence.

**Returned Checks:** A $25 charge is applied when a check is returned by the bank.

**Minor Patients:** The parent or guardian that signs the financial agreement will be responsible for the treatment charges.

Please indicate your understanding and acceptance of these financial policies by signing below. For the mutual convenience of you and the practice, it is understood that this executed copy of the Financial Agreement covers your dependent children who are also patients of the practice.

Patient's Name (please print): _____

Patient Signature: _____ Date: _____