TIME 12:17 PM DATE 2/12/2015

PATIENT REGISTRATION

ID: ______ Chart ID: ______

First Name: ______ Last Name: ______ Middle Initial: ______

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name: ______

Responsible Party (if someone other than the patient)

First Name: ______ Last Name: ______ Middle Initial: ______

Address: ______ Address 2: ______

City, State, Zip: ______ Pager: ______

Home Phone: ______ Work Phone: ______ Ext: ______ Cellular: ______

Birth Date: ______ Soc Sec: ______ Drivers Lic: ______

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

Patient Information

Address: ______ Address 2: ______

City: ______ State / Zip: ______ Pager: ______

Home Phone: ______ Work Phone: ______ Ext: ______ Cellular: ______

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

Birth Date: ______ Age: ______ Soc Sec: ______ Drivers Lic: ______

E-mail: ______ ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: ______ Pref. Dentist: ______

Employer ID: ______ Pref. Pharmacy: ______

Carrier ID: ______ Pref. Hyg: ______

Section 3

Referred By ______

Previous Dentist ______

Emergency Contact ______

Emergency Contact # ______

Primary 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: ______

Rem. Benefits: ______ Rem. Deduct: ______

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: ______

Rem. Benefits: ______ Rem. Deduct: ______

Sweet Tooth Dentistry Medical History Form

Patient Name: Birth Date: Date Created:

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

Question	Answer	If yes
Are you under a physician's care now?	Yes No	If yes
Have you ever been hospitalized or had a major operation?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Are you taking any medications, pills, or drugs?	Yes No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Do you require pre-medication prior to your dental appointment?	Yes No	If yes
Are you on a special diet?	Yes No	
Do you use tobacco?	Yes No	

Women: Are you...

- ☐ Pregnant/Trying to get pregnant?
- ☐ Nursing?
- ☐ Taking oral contraceptives?

Are you allergic to any of the following?

- ☐ Aspirin
- ☐ Penicillin
- ☐ Codeine
- ☐ Acrylic
- ☐ Metal
- ☐ Latex
- ☐ Sulfa Drugs
- ☐ Local Anesthetics

Question	Answer	If yes
Do you use controlled substances?	Yes No	If yes
Other?	☐	If yes

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

Condition	Answer	Condition	Answer	Condition	Answer	Condition	Answer
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 Problems	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 Yes No If yes

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:

X Date:__________

Sweet Tooth Dentistry Financial Policies and Options

In addition to providing the highest quality of dental care available, we are dedicated to making your dental care as cost effective as possible. In order to assist you with your healthcare investment, we offer payment options.

Patients are expected to pay all fees for dental services provided. After examination and diagnosis, a complete description of the required treatment and written proposed treatment plan will be provided to the patient. For our patients with dental insurance coverage, only their estimated portion is due when dental services are provided.

If the patient's dental treatment plan is greater than $1000, payment must be arranged regardless of any insurance benefit. Our patient care coordinator will be happy to assist in setting up a payment arrangement best suited for each patient’s financial needs.

Dental Insurance

Sweet Tooth Dentistry is a provider for many major insurance companies. Due to varying coverages for different insurance plans, please be sure to verify your coverage and ask any questions you might have before your appointment. Most insurance companies will not cover 100% of your dental services. Patient portions not covered by insurance is due at the time treatment is provided. As a courtesy to our patients, we can contact you to review costs and arrange payments as needed. Please remember that a preauthorization is not a guarantee of payment by your insurance company. Patients will ultimately be responsible for the total balance of fees should their insurance coverage result in less coverage than originally estimated. The patient is still the responsible party for all dental fees.

Flexible Payment Options**

1. Cash or Check (We offer a 5% discount for uninsured patients who pay in full the same day services are provided. For uninsured patients 60 years or older, we offer a 10% senior discount (No discounts are given with debit cards). A $30 fee applies to returned checks.**

2. We accept Visa, MasterCard and Discover (there are no discounts with credit cards).

3. 30-day payment plan option with Sweet Tooth Dentistry for amounts over $1000: 1st payment equal to ½ of patient estimated portion is due when treatment is initiated. 2nd payment for the remaining balance is due within 30 days.

4. CareCredit financing is available for patients who would like to extend payments past 30 days (subject to credit approval).

***Upon any violation of the financial policy, flexible payment options are surrendered by patients.*

A finance charge of 1.5% per month (18% per year) will be applied on account balances after 90 days.

Billing Statement

We will send a billing statement to all patients insured and uninsured if you have a remaining balance. If your insurance company has not paid on a claim after 30 days please contact them to resolve. After contacting your insurance company and if you need our assistance please do not hesitate to call. Payment is due in full upon receipt of your billing statement unless a payment arrangement has already been made.

Patient Name (Please Print):____

I acknowledge I have read the financial policies and options information and agree to the terms and conditions contained herein.

Signature of Responsible Party (Parent/guardian if patient is a minor): ____________________________

Sweet Tooth Dentistry
Acknowledgement and Consent for Use and Disclosure of Health Information

NAME:____DOB:____________________
ADDRESS:____CITY:__________________
TELEPHONE: (H)_______________________________CELL:_____________________________
EMAIL:____

Section B: To the Patient - Please read the following statements carefully.
Notice of Privacy Practices: you have the right to read our Notice of Privacy Practices before you decide 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 our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.
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.
Purpose of Acknowledgment: by signing this form, you acknowledge you have had the opportunity to read our Notice of Privacy Act for Sweet Tooth Dentistry.
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 paply to any of your protected health information that we maintain.

You may obtain a copy of Notice of Privacy Practices, including any revision of our Notice, at any time by contacting:

Contact Person: Kate Greig
Telephone: 763.639.1763
Address: 1573 154th Avenue NW, Suite 107, Andover, MN 55304

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your 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:
I,____________________________________, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.
Signature:____Date:____________________________

If this consent is signed by a personal representative on behalf of the patient, complete the following:
Personal Representative's Name:____
Relationship to Patient:____

You are entitlted to a copy of this consent after signing. Completed consent included in patient's chart.

Revocation of Consent
I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat me after revocation of my Consent.

Signature:_______________________________________Date:____________________________