# Patient Registration

**PATIENT** **Today's Date** _______________

Name: Last______________________ First ________________________ MI ___ Sex: M F Birthday: ___________

Soc. Sec. # __________________ If Patient is a Minor, give Parent's or Guardian's Name _____________________

How did you hear about our Office? _________________________ Reason for Visit: ________________________

How long has it been since you've seen a Dentist? ______ Name of Previous Dentist_______________________

**RESPOSIBLE PARTY**
*(If you are 18 years or older this information is about YOU)*

Name: Last _________________________ First ________________________ MI ___ Martial Status _____________

Residence: Street ______________________________ Apt# ____ City _______________ State ___ Zip _________

Mailing Add: Street ______________________________ Apt# ____ City _______________ State ___ Zip _________

Soc. Sec. # ___________________ Birthdate _______________ Driver's License # ________________ State ____

Employer ______________________________ Occupation _________________________ No. Yrs Employed _____

Home Ph. ______________________ Cell Ph. _________________________ Work Ph. _________________________

Email _______________________________________ Preferred method of contact: Phone call Text Email

**SPOUSE** *(of responsible party)*

Name: Last ___________________________ First ____________________________ MI ___ Birthday: ____________

Soc. Sec # ___________________ Employer: ________________________ Occupation: _______________________

Home Ph. ______________________ Cell Ph. _________________________ Work Ph. _________________________

**EMERGENCY CONTACT** *(Relative or Friend other than Spouse)*

Name: __________________________________________ Relationship: ______________________________________

Address: ______________________________________________ City, State, Zip: ______________________________

Home Ph. ______________________ Cell Ph. _________________________ Work Ph. _________________________

**DENTAL INSURANCE INFORMATION**

**PRIMARY:**

Name of Insured: ______________________________ Relationship to Insured: __Self __Spouse __Child __Other

Insured Soc. Sec. # ________________________ Insured Birthdate: ____________ Policy No. _________________

Employer: _______________________________ Ins. Company: ________________ Group No. __________________

Address of employer: ______________________ Dental Claims Mailed to: ____________________________

City, State, Zip: ____________________________ Ins. Ph. _______________City, Sate, Zip: _______________

**SECONDARY:**

Name of Insured: ______________________________ Relationship to Insured: __Self __Spouse __Child __Other

Insured Soc. Sec. # ________________________ Insured Birthdate: ____________ Policy No. _________________

Employer: _______________________________ Ins. Company: ________________ Group No. __________________

Address of employer: ______________________ Dental Claims Mailed to: ____________________________

City, State, Zip: ____________________________ Ins. Ph. _______________City, Sate, Zip: _______________

****PLEASE BE SURE ALL INFORMATION IS FILLED OUT****

# Eaglesoft Medical History

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 that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

| Question | | | |
|---|---|---|---|
| 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 | |
| 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 |

Other? ☐ If yes

Do you use controlled substances? ○ Yes ○ No If yes

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

| Condition | | Condition | | Condition | | Condition | |
|---|---|---|---|---|---|---|---|
| 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:___________

**Richard D. Troutman, D.D.S.**
1985 Tate Blvd SE, Suite 757
Hickory NC 28602
828-322-4627

## Financial Policy

- All payment is **due at time of services** rendered.
- We accept the following forms of payment: **Cash, Check, Visa, Master Card, and Discover.**
- Checks that are returned to our office from your financial institution are subject to a **$25.00 returned check fee**.
- For multi-appointment procedures (i.e., partials, crown and bridge), a **50% deposit will be required at the start of the appointment.** The remaining balance must be paid in full prior to completion of the treatment.

## Cancellation Policy

Appointments that you make for follow up care and preventative treatment have been reserved just for you. Broken appointments affect many patients. A charge will be made for broken appointments unless 24 hours notice is given. A **fee of $25.00** will be automatically applied to your account each time you fail to keep your appointment regardless of reason. Depending on circumstances that caused the missed appointment we may choose to waive this fee. If three or more appointments have been broken your patient status with our office will be reviewed and may have grounds for dismissal.

## HIPAA Policy

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. We may use and disclose your health information for different purposes including:

1.) Treatment to other dental health care providers involved in your treatment.
2.) Payment to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care (i.e., insurance companies and collection agencies).
3.) Health care including day to day operations of the dental practice.

I also understand that I may request to see a copy of the Notice of Privacy Practices (located in the front office), which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand the Dr. Troutman may change the terms of this notice. I understand that I have the right to request restrictions on how my protected health information is used but that Dr. Troutman is not required to agree to use these restrictions. I may revoke my consent, in writing, at any time but any use or disclosure that occurred prior to the date I revoke this consent will not be affected.

## Dental Insurance

Dental insurance coverage can be confusing. A common misunderstanding is that dental insurance will pay for all your dental care. But, please understand that, like medical insurance, **it is not designed to pay for all your dental care.**

Dental insurance contracts can vary in coverage. Most contracts have yearly limits, deductibles, treatment limitations and/or various degrees of co-payments as well as IN and OUT of Network Benefits. Insurance companies allow fees that are (UCR) usual, customary, and reasonable and are based on the premiums paid, not on the actual fee for the services rendered. Our fees are based upon material costs and our time. The fee for service does not always line up with what the dental plan will cover. **Any cost not covered by the insurance company is the patient's responsibility.**

The treatment recommended by our practice is based on the best interest of your oral health care, not on what your insurance companies will pay. Our practice has no way of knowing the exact amount of coverage for each individual insurance plan. We can however, offer an estimate of coverage and submit a pre-treatment estimate to know in advance what procedures are covered. Please note that pre-treatment estimates are not a guarantee of payment.

It should be understood that the dental insurance contract is between the insurance company and the patient, not our practice. As a courtesy to you we will be glad to file your insurance claims, and will do our best to help you get the most out of your dental benefits. **Once the insurance claim has been paid, a statement will be sent to you and the unpaid balance becomes your responsibility and is subject to late charges and the collection process.**

We hope this information has been helpful. Please be sure to review your insurance policy and your benefits to better understand your coverage.

**Richard D. Troutman, D.D.S.**
1985 Tate Blvd SE, Suite 757
Hickory NC 28602
828-322-4627

**I have read and understand the Financial Policy, Cancellation Policy, HIPAA Policy and Dental Insurance.**

Patient Name: ___________________________________

Patient Signature: _________________________________________ Date: _____________

## AUTHORIZATION FOR TREATMENT

I request and authorize the dental staff to perform necessary dental services, including but not limited to X-ray films and administration of anesthetics which are deemed advisable by the doctor. I authorize the dental staff to release any information including diagnostics and the records of any treatment and examination rendered to third party payers and/or other dental practitioners. I authorize and request my insurance company to pay directly to the dentist, insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that at any time I may ask and receive a copy of the Notice of Privacy Practices.

**X** _______________________________________________________ Date: ______________