TIME 12:57 PM

DATE 12/11/2017

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 #

care credit #

credit card#

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:

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	Answer	
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	
Do you use controlled substances?	◯ Yes ◯ No	If yes

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 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 above? ◯ 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:__________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

****You May Refuse to Sign This Acknowledgement****

I ____ have received a copy of this office's Notice of Privacy Practices.

Print Name: ____

Sign: ____

Date: ______________________

Authorization to Release Information

Purpose: This form is used to obtain authorization to release information regarding you covered under the Privacy Act to people other than yourself. I, ______________________ authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

____

{Please Print Name} Relationship

____

{Please Print Name} Relationship

____

{Please Print Name} Relationship

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify) ____

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Financial Policy for Our Patients

Our goal is to make dental care affordable for all our patients. In our continued effort to keep prices down, we offer the following financial options so that you may decide which form of payment best suits your needs:

INSURANCE: Our office will gladly work with you to help get the maximum benefit available to you. Most dental insurance plans **DO NOT** cover **100%** of your cost of treatment. Because of this, you will be asked to pay your deductible and your co-payment for the charges on the day the service is rendered. We will **ESTIMATE:** as closely as possible your coverage, but we can make no guarantee of any estimated coverage.

Because your insurance plan is an agreement between you and your insurance company, the ultimate responsibility for all charges lies with you. If after 60 days the insurance company has not paid on the claim, you will be responsible for the remaining balance.

APPOINTMENTS: Since we see patients on a reserved appointment basis, we ask for a **48 HOUR** notice to cancel or reschedule any appointments. You will be charged $50.00 per hour of appointment time failed. Failure to give a **48 HOUR** notice more than twice will require us to ask for payment for all charges in advance before we can reserve time for future appointments.

PAYMENT OPTIONS:

1. **CASH, CHECK or PREPAYMENT**
2. **CREDIT CARD:** We accept VISA, MasterCard, Discover and American Express on the date of service.
3. **CARE CREDIT:** Flexible monthly payments. 0% interest for 12 months. Extended monthly payments with a fixed rate.

I acknowledge receipt of a copy of this form

Signature: ______________________ Date: ______________

Dr. Craig Hine, D.D.S. Craig Hine D.D.S.

12345 S. Memorial Drive #103 Bixby, OK 74008 PH (918) 364-4463 FAX (918) 364-4465

How did you hear about Hine Dental?

- Mail Piece (Postcard)
- Flyer
- Yelp
- Google Ad
- Facebook
- Hinedental.com (web site)
- Other Internet Site
- TV commercial
- Billboard
- Magazine Ad
- Newspaper
- Location- Roadside sign
- Bixby Public Schools
- Friend ______________________
- Family ______________________
- Other ______________________

Hine Dental
12345 S. Memorial Drive, Ste. 103
Bixby, OK 74008

(918)364-4463

WWW. HineDental.com

Patient Name: ______ **Preferred Name:** ______

1. Which describes your frequency of dental visits?

   ○ Every 6 Months ○ Every 1-2 years ○ In an emergency

2. Are you pleased with the appearance of your teeth when you smile?

   ○ Yes ○ No

3. Describe your approach to Dentistry using the following scale

   1-I prefer to fix the problems when they are small, simple and easy

   5- I only want to fix something after it is broken or I feel pain

   ○ 1 ○ 2 ○ 3 ○ 4 ○ 5

4. Are your teeth?

   ○ Chipped ○ Sticking out ○ Crowded ○ Spaced

5. Are you interested in straightening your teeth?

   ○ Yes ○ No

6. Do you have any crowns or fillings you are unhappy with

   ○ Yes ○ No

7. Are you interested in whitening your teeth?

   ○ Yes ○ No

8. What would you like to change (if anything) about the appearance of your smile?

Video/Photography Release Form

I, ______________________, hereby authorize Hine Dental, permission to use any video or photography taken of me, in any and all publications for promoting their business. I acknowledge that the photos and videos will be property of Hine Dental and I will receive no compensation for their use.

By signing this release, I acknowledge that I have read and agree to the above statement and I am at least 18 years of age and am competent to contract my own name.

Signature: ______________________________ Date: ____________

Printed Name: ____________________________

If the patient is under the age of 18, a parent or legal guardian must sign this release.

Parent/Guardian Signature: ________________________ Date: ____________

Printed Name: ______________________________________

Patient Name: ______________________________________