PATIENT REGISTRATION

Today's Date:_____

Name:_____
☐Mr. ☐Mrs. ☐Ms. ☐Dr. LAST FIRST MIDDLE

I prefer to be called: _____☐Male ☐Female

Birthdate: ____/_____/_____ Age:_____ SSN_____

Home Address: _____

_____

_____

City State Zip

Home Phone:(____)_____Cell #:(____)_____

Work Phone:(____)_____Ext:___Pager:(____)_____

E-Mail Address:_____

I prefer to be contacted by:
☐Home Phone ☐Cell Phone ☐Work Phone ☐E-Mail

Employer: _____

Occupation:_____

Full time College Student? ☐Yes ☐No

School_____City_____State_____

When are the best times to reach you? _____☐am _____☐pm

How did you hear about Relaxation Dentistry?_____

Previous/Present Dentist:_____
(Please Circle One)

Spouse Information:

His/Her Name:_____

Employer:_____

Position:_____Social Security #:_____

Work Phone(_____)_____Ext._____

Person Responsible for Account(If other than yourself)

Name:_____

Billing Address:_____

Employer:_____

Home Phone: (____)_____ Cell #:(___)_____

Work Phone: (____)_____ Ext.:_____

Relationship: _____SSN: _____

In the event of an emergency, whom should we contact?

His/Her Name:_____Relation:_____

Work Phone(___)_____Home Phone(___)_____

Thank you for filling out this form completely.
If you have any questions please ask us.

CANCELLATION POLICY

In order to maintain the highest level of individualized care for each of our patients, we reserve a generous amount of time for each person's appointment. This allows us to stay on time and focus on each person's needs without being rushed. The time that we have reserved for your appointment is for you and you alone. We have not double-booked your appointment in case you cancel short-notice or don't show up. Please help us to continue to be able to maintain a high level of care by **kindly giving us at least two days notice if you need to cancel or change your appointment.** Missed appointments canceled with less than 24 hours notice, or missed completely, may be billed to you at **$85/hour**.

Acknowledgment of Cancellation Policy:

Signature_____Date_____

AUTHORIZATIONS

I affirm that the information I have given today is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes.

_____ _____
Signature Date

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with_____ and assign directly to Relaxation Dentistry all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Responsible Party Signature

_____
Relationship

_____
Date

OVER ➔ ➔ ➔ ➔

DENTAL HISTORY

Reason for today's visit?_____

_____

_____

Former Dentist:_____

_____

City/State:_____

Date of last dental visit?_____

Date of last dental x-rays_____

Place a mark on "**Yes** " or "**No**" to indicate if you have had any of the following:

Bad Breath ☐Yes ☐No

Bleeding gums ☐Yes ☐No

Blisters on lips or mouth ☐Yes ☐No

Burning Sensation on tongue ☐Yes ☐No

Chew on one side of mouth ☐Yes ☐No

Cigarette, pipe or cigar smoking ☐Yes ☐No

Tobacco Type?_____How much?_____

Clicking or popping jaw ☐Yes ☐No

Dry mouth ☐Yes ☐No

Fingernail biting ☐Yes ☐No

Food collection between the teeth ☐Yes ☐No

Grinding teeth ☐Yes ☐No

Gums swollen or tender ☐Yes ☐No

Jaw pain or tiredness ☐Yes ☐No

Lip or cheek biting ☐Yes ☐No

Loose teeth or broken Fillings ☐Yes ☐No

Mouth breathing ☐Yes ☐No

Mouth pain, brushing ☐Yes ☐No

Orthodontic treatment ☐Yes ☐No

Pain around ear ☐Yes ☐No

Periodontal treatment ☐Yes ☐No

Sensitivity to cold ☐Yes ☐No

Sensitivity to heat ☐Yes ☐No

Sensitivity to sweets ☐Yes ☐No

Sensitivity when biting ☐Yes ☐No

Sores or growths in your mouth ☐Yes ☐No

How often do you floss?_____

How often do you brush?_____

HEALTH HISTORY

Physician's Name:_____Date of last visit:_____Phone:_____

Place a mark on "**Yes**" or "**No**" to indicate if you have had any of the following:

AIDS ☐Yes ☐No

Alzheimers ☐Yes ☐No

Anemia ☐Yes ☐No

Arthritis, Rheumatism ☐Yes ☐No

Artificial Heart Valves ☐Yes ☐No

Artificial Joints ☐Yes ☐No

Asthma ☐Yes ☐No

Back Problems ☐Yes ☐No

Bleeding abnormally, with extractions or surgery ☐Yes ☐No

Blood Disease ☐Yes ☐No

Bruise Easily ☐Yes ☐No

Cancer ☐Yes ☐No

Chemical Dependency ☐Yes ☐No

Chemotherapy ☐Yes ☐No

Circulatory Problems ☐Yes ☐No

Congenital Heart Defects ☐Yes ☐No

Cortisone Treatments ☐Yes ☐No

Cough, persistent or bloody ☐Yes ☐No

Diabetes ☐Yes ☐No

Emphysema ☐Yes ☐No

Do you wear contact lenses? ☐Yes ☐No

Epilepsy/Seizures ☐Yes ☐No

Fainting or dizziness ☐Yes ☐No

Glaucoma ☐Yes ☐No

Headaches ☐Yes ☐No

Heart Murmur ☐Yes ☐No

Heart Problems/Disease ☐Yes ☐No

Type_____

Hepatitis.....Type_____ ☐Yes ☐No

Herpes.....Type_____ ☐Yes ☐No

High Blood Pressure ☐Yes ☐No

HIV Positive ☐Yes ☐No

Jaundice ☐Yes ☐No

Jaw Pain ☐Yes ☐No

Kidney Disease ☐Yes ☐No

Liver Disease ☐Yes ☐No

Low Blood Pressure ☐Yes ☐No

Mitral Valve Prolapse ☐Yes ☐No

Nervous Problems ☐Yes ☐No

Pacemaker ☐Yes ☐No

Women:

Are you pregnant? ☐Yes ☐No

Due date:_____

Are you nursing? ☐Yes ☐No

Psychiatric Care ☐Yes ☐No

Radiation Treatment ☐Yes ☐No

Respiratory Disease ☐Yes ☐No

Rheumatic Fever ☐Yes ☐No

Scarlet Fever ☐Yes ☐No

Shortness of Breath ☐Yes ☐No

Sinus Trouble ☐Yes ☐No

Snoring/Sleep Apnea ☐Yes ☐No

Excessive Daytime Sleepiness ☐Yes ☐No

Skin Rash ☐Yes ☐No

Special Diet ☐Yes ☐No

Stroke ☐Yes ☐No

Swelling of Feet or Ankles ☐Yes ☐No

Swollen Neck Glands ☐Yes ☐No

Thyroid Problems ☐Yes ☐No

Tonsillitis ☐Yes ☐No

Tuberculosis ☐Yes ☐No

Tumor or growth on Head or neck ☐Yes ☐No

Ulcer.....Type_____ ☐Yes ☐No

Weight Loss, Unexplained ☐Yes ☐No

Dental Anxiety ☐Yes ☐No

Other (describe): _____

_____

If a healthcare worker is exposed to my blood or body fluids through a needle stick or otherwise, I agree to have my blood tested for blood-borne diseases to include Hep B or C and HIV (AIDS). Initial:_____

MEDICATIONS

List medications you are currently taking and why you are taking them:

_____

_____

_____

_____

History of Bone Density Meds (e.g. Boniva, Fosamax)?_____

How long were you taking them?_____

Do you need to take an antibiotic prior to dental appt?_____

Pharmacy Name:_____Phone_____

Would you like to speak to the doctor in private?_____

ALLERGIES

☐Aspirin

☐Barbiturates (Sleeping Pills)

☐Codeine

☐Iodine

☐Latex

☐Local Anesthetic

☐Penicillin

☐Sulfa

☐Other_____

_____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

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.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether 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 maters 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.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

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

Patient Coordinator
1464 White Oak Drive
Chaska, MN 55318
(952)351-8282

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, _____, can receive a copy of this office's Notice of Privacy Practices upon request (see summary of privacy practices above).

_____
Please Print Name

_____
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: _____

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 or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

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
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify): _____

OVER ➔ ➔ ➔ ➔

Relaxation Dentistry Financial Policy

Thank you for choosing our practice for your dental care. We realize that every person's financial situation is different. In effort to keep our overall costs down, we have eliminated billing for any treatment received in our office. By eliminating the need to generate thousands of billing statements, time spent tracking accounts, and postage for mailing statements, we are able to keep our fees lower than average. In fact, we do pass the savings on to each of our patients by having below average fees for **ALL** our services.

Our payment options include the following:

1. **Payment is due in full at the time of your visit**: We accept Cash, check, debit or credit card.
2. **Major service; two payment option:** We offer a two payment option for crown, bridge, and denture treatment. We ask that you pay one-half of your co-payment at the first appointment and the second half at the delivery date appointment.
3. **In office payment plan:** Allows you to make three equal monthly installments with postdated checks or credit card. One third is due at the first appointment, one-third is due thirty days later, and the remaining one-third is due sixty days from the initial appointment. Our office personnel will charge these payments by processing your credit card on the due dates. Eligibility for this option will be determined on an individual basis.
4. **Term Loan**: By arrangement with Care Credit, we offer an interest -free term loan: For balances 1,001.00-2,000.00 6 months interest-free, and balances over $2,000 12 months interest-free; with no down payment, no annual fee, and no prepayment penalty. You must qualify **prior** to treatment for Care Credit to be eligible for this option.

Dental Insurance As a courtesy and service to you, we are happy to verify your insurance benefits and file all insurance claims for you. Most insurance companies will not release their "Maximum Allowable Fees" to us. This means we can only ESTIMATE what your insurance will pay. For example, if your insurance tells us they will pay 100% for a cleaning but their "maximum allowable" for that procedure is only $40; than your insurance will only pay $40 towards the service while our fee is $70. We can estimate very close to the exact amount for preventative dentistry (cleanings, exams, x-rays, etc.), but we strongly encourage a pre-authorization for restorative or major dental procedures if you need to know an exact amount. Pre-authorization could delay treatment about 4-6 weeks. **You are responsible for any balance on your account not covered by insurance.**

Finance, Billing & Collection Charges: We impose a surcharge of 3% on purchases made with a credit card (does not apply to debit card purchases). This surcharge is not greater than our cost of acceptance. Delinquent accounts increase the cost of care for all our patients. Please help keep care affordable by maintaining an account in good standing. A monthly finance charge of 1.5% (Annual Percentage Rate 18%) is calculated on account balances greater than 30 days old. A billing charge of $5.00 per statement is calculated on account balances below $100. Account balances over 90 days delinquent may be turned over to a collection agency. All collection costs will be added to your account at the rate of up to 45% of your total account balance.

I have read and understand the financial policy for Relaxation Dentistry.

Signature_____**Date**_____