PATIENT REGISTRATION

PATIENT INFORMATION

PATIENT'S NAME Last _____ First _____ Middle Initial _____ Preferred Name: _____

Soc. Sec. # _____ SEX: _____ BIRTHDATE _____ AGE _____ FT Student: Y N If yes, Where: _____

Whom May We Thank for Referring You to our Office? _____

RESPONSIBLE PARTY INFORMATION

NAME Last _____ First _____ Middle Initial _____ MARITAL STATUS _____

RESIDENCE Street _____ Apt # _____ City _____ State _____ Zip _____

If Different from Above:

MAILING ADDRESS Street _____ Apt # _____ City _____ State _____ Zip _____

HOME PHONE _____ CELL PHONE _____ WORK PHONE_____

EMAIL _____ May we Text you Appointment Reminders: _____ YES _____ NO

SOCIAL SECURITY # _____ BIRTHDATE _____ DRIVER'S LICENSE # _____ RELATION TO PATIENT_____

EMPLOYER _____ Phone Number_____ .

PATIENT CONTACT INFORMATION

PATIENT CELL PH_____ PATIENT WORK PH._____ _____

May we text reminders Y N

PATIENT E-MAIL _____

EMERGENCY INFORMATION: RELATIVE NOT LIVING WITH YOU.

NAME _____

RELATIONSHIP_____

HOME PH. _____ CELL PH. _____

WORH PH. _____

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name _____

Insurance Co. _____ E-MAIL _____

Insurance Co.Phone _____

Insured's Employer _____

Insured's Date of Birth _____

Insured's Soc. Sec. # _____ Group # _____ ID#_____

If you have secondary dental insurance coverage, complete this for the second coverage.

Insured's Name _____

Insurance Co. _____ E-MAIL _____

Insurance Co. Address _____

Insured's Employer _____

Insured's Soc. Sec. # _____ Group # _____ ID # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance cover with the above named insurance company and assign directly to Summer Creek 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 authorize the use of my signature on all insurance submissions. This assignment and release will apply to any new insurance provided to the office in the future

Summer Creek Dentistry and Dr. Jasmine Coleman may use my health care information and may disclose such information to the above-names insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. The Doctor also has my consent to use any photos taken without identifying information or full face, for use in journals, office use, website, and other advertising.

PATIENT Signature (Parent of Child) _____ Date: _____ DENTIST Signature _____

NAME: DENTAL HISTORY

Please check any of the following that apply:	Yes	No
-Sensitivity (hot, cold, sweet) Where? UR LR UL LL	☐	☐
-Headaches, earaches, neck pain	☐	☐
-Jaw joint pain	☐	☐
-Teeth or fillings breaking	☐	☐
-Grinding or clenching teeth	☐	☐
-Bleeding, swollen or irritated gums	☐	☐
-Loose, chipped or shifting teeth	☐	☐
-Bad breath	☐	☐
Do you know or have you been told that you snore?	☐	☐
Do you smoke or use chewing tobacco? How much? For how long?	☐	☐

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

-Dentures	☐	☐
-Partial dentures	☐	☐
-Braces	☐	☐
-Gum treatments	☐	☐

	Yes	No
If you could whiten your teeth for a cost anyone could afford, would you do it?	☐	☐
If I could change my smile, I would:		
-Make them whiter	☐	☐
-Make them straighter	☐	☐
-Close spaces	☐	☐
-Repair chipped teeth	☐	☐
-Replace black metal fillings with tooth colored restorations	☐	☐
-Replace missing teeth	☐	☐
-Replace old crowns that don't match	☐	☐
-Have a smile makeover	☐	☐

On a scale of 1 – 10, with 10 being the highest rating:

-How important is your dental health to you?
1 2 3 4 5 6 7 8 9 10

-Where would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10

What is the most important thing to you about your dental visit today?

What is the most important thing to you about your future smile and dental health?

MEDICAL HISTORY

Please check any of the following that apply to you:

☐ AIDS	☐ Drug Addiction	☐ HIV Positive	☐ Rheumatic Fever
☐ Allergies (Seasonal)	☐ Emphysema	☐ Jaundice	☐ Rheumatism
☐ Anemia	☐ Excessive Bleeding	☐ Jaw Joint Pain	☐ Scarlet Fever
☐ Arthritis	☐ Fainting	☐ Kidney Disease	☐ Seizures
☐ Artificial Heart Valve	☐ Glaucoma	☐ Liver Disease	☐ Stomach Problems
☐ Artificial Joints	☐ Heart Conditions	☐ Low Blood Pressure	☐ Stroke
☐ Asthma	☐ Heart Lesions (Congenital)	☐ Mitral Valve Prolapse	☐ Thyroid Disease
☐ Blood Disease	☐ Heart Murmur	☐ Nervousness/Depression	☐ Tuberculosis
☐ Bruise Easily	☐ Heart Surgery	☐ Pacemaker	☐ Ulcers
☐ Cancer	☐ Hepatitis A	☐ Phen Fen (1 month +)	☐ Venereal Diseases
☐ Chemotherapy	☐ Hepatitis B	☐ Pregnant Currently	☐ HPV Positive
☐ Diabetes	☐ Hepatitis C	☐ Radiation (head/neck)	☐ Other
☐ Dizziness	☐ High Blood Pressure	☐ Respiratory Problems	

Do you have any of the following drug allergies?

☐ Aspirin	☐ Codeine	
☐ Sulfa	☐ Erythromycin	
☐ Nitrous Oxide	☐ Valium	
☐ Percodan	☐ Penicillin	
☐ Local Anesthetic	☐ Latex	☐ Other

Are you under a physician's care? What for?

_____

Are you taking any medications? What?

_____

Family Physician _____ **Phone Number** _____

Is there any other medical or dental information we should know about?_____

Patient Signature *(Parent of Child)* _____ **Dentist Signature** _____ **Date** _____

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

_____ _____

Please ***print*** name of Patient Please ***sign*** for Patient / Guardian of Patient

_____ _____

Legal Representative / Guardian Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents: _____

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

☐ First Name Only ☐ Proper Surname ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

□ Phone Message
□ Text Message
□ Email
☐ **Any of the Above**
☐ **None of the above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment ____
I could not communicate with the patient ____
The patient refused to sign ____
The patient was unable to sign because ____
Other (please describe) ___ _____

Signature of Privacy Officer

Office Orientation and Financial Information

We are pleased that you have chosen our office for your dental needs. Below is information to assist you in understanding our services and to help familiarize you with our office.

_____ Appointment Cancellation/Reschedule Information: If you are ever unable to keep an appointment you have scheduled with us, please notify us at least 24 hours (no less than 1 business days) in advance. This allows us the opportunity to see another patient, who may wish to fill that open time. We reserve the right to charge a $50 fee for all missed appointments and short notice cancellations. If a history of short notice cancellations or "no shows" has been established, you may be required to pre-pay for your dental visits before being rescheduled. You can email us 24 hours in advance at info@summercreekdentistry.com. **We respect your time** and ask that you do the same with ours. Our office will call to remind you about your appointment 1-2 days ahead of your scheduled appointment.

Dental Emergencies: Please call our office for further instructions in emergency situations after office hours. Please follow the prompts and leave a message and your call will be returned. In some instances it might take 30-45 minutes for your page to reach to office. Please leave all numbers at which you can be reached.

Dental Treatment: Beyond our most calculated efforts, further necessary treatment may arise during a dental procedure that was not originally diagnosed. This treatment will incur additional fees that you will be responsible for. Should this situation arise, the Doctors will inform you of these changes.

Insurance: Dr. Coleman is ***in-network*** with most insurance plans. With our extensive knowledge and experience, our insurance experts can help you maximize your insurance benefits. However, it is important to remember that the insurance is a contract between you and the insurance company. We are happy to assist you in following up with your insurance company, writing appeals and necessary narratives for payment, this is offered as a courtesy to you. Insurance not paid in 60 days will be the responsibility of the patient. You will need to supply your insurance information in order for us to submit the claim.

*Please note there will be a $25 charge on all returned checks.

Financial Payment Options: Please initial your choice of payment option.

_____ **Option 1:** Payment in full at the start of treatment. We will file your insurance as a courtesy to you and the insurance company will reimburse you directly for your services.

_____ **Option 2:** Patient financing through our partnership with Care Credit or Lending Club. 6, or 12 Months Interest Free for charges over $1000. We pay the interest for you! We also offer extended financing up to 48 months for a low interest rate.

_____**Option 3:** We will file and accept Assignment of Benefits from your Insurance Company and You are responsible for your **estimated** portion when services are rendered. This option requires a credit card authorization be placed on file with us so that any remaining balance after your insurance has paid will be cleared from your account. **Please note that insurance balances not paid within 60 days of the date of service** will be run on the credit card on file. Please understand that your insurance is a contract between you and the insurance company, filed as a courtesy to you, by our office.

_____**Option 4: In Office Savings Plan –** Payment directly to the dental practice for a period of three months in advance of dental care.

_____

Patient Signature (Parent or Guardian, if patient is under the age of 18)

Auto Pay
Credit Card Authorization

Complete only if choosing Option 3 on Financial Form

Date: _____

Name:_____

Credit Card: MC VISA DISCOVER AMEX

Credit Card Number : _____

EXP: _____ CVV Code :_____

I authorize Jasmine Coleman, DDS to charge the credit card listed above should any balance remain on my account after my insurance company completes processing my claims**. I understand that my insurance is a contract between myself and my insurance company and that Dr. Coleman's staff is filing the claim as a courtesy to me. I understand that I am fully responsible for all charges on my account regardless of insurance coverage.**

_____

Patient Signature

Attach credit card copy