PATIENT REGISTRATION APEX DENTAL

PATIENT INFORMATION

PATIENT'S NAME Last ______________ First ______________ Middle Initial ______ SEX: M F BIRTHDATE ______________ AGE ______

Soc. Sec. # ______________ If Patient is a Minor, give Parent's or Guardian's Name ______________ TODAY'S DATE ______________

Who May We Thank for Referring You to our Office? ______________ Reason for this Visit ______________

RESPONSIBLE PARTY INFORMATION

NAME Last ______________ First ______________ Middle Initial ______________ MARITAL STATUS ______________

RESIDENCE Street ______________ Apt # ______ City ______________ State ______________ Zip ______________

MAILING ADDRESS Street ______________ Apt # ______ City ______________ State ______________ Zip ______________

HOW LONG AT THIS ADDRESS ______________ HOME PHONE ______________ CELL PHONE ______________

WORK PHONE ______________ EMAIL ______________

PREVIOUS ADDRESS (if less than 1 yr.) Street ______________ City ______________ State ______ Zip ______________ How Long______________

SOCIAL SECURITY # ______________ BIRTHDATE ______________ DRIVER'S LICENSE # ______________ RELATION TO PATIENT______________

EMPLOYER ______________ OCCUPATION ______________ NO. YEARS EMPLOYED______________

RESPONSIBLE PARTY'S SPOUSE

NAME ______________
LAST FIRST MIDDLE

EMPLOYER ______________ OCCUPATION ______________

SOC. SEC. # ______________ BIRTHDATE ______________

HOME PH. ______________ CELL PH. ______________

WORK PH. ______________ E-MAIL ______________

EMERGENCY CONTACT INFORMATION:

NAME ______________ RELATIONSHIP______________

ADDRESS ______________ CITY, STATE______________

HOME PH. ______________ CELL PH. ______________

WORH PH. ______________

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name ______________

Insurance Co. ______________ E-MAIL ______________

Insurance Co. Address ______________

Insured's Employer ______________

Insured's Soc. Sec. # ______________ Group # ______________

If you have double 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 # ______________

Do you REGULARLY use DENTAL FLOSS? **Yes ☐** **No ☐**	
NAME OF PREVIOUS DENTIST?	
City: State: phone#:	
Date o f last exam/cleaning:	
PHARMACY YOU PREFER TO USE?	

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

If you are the parent,(guardian) bringing the child you are the responsible party for treatment rendered

PATIENT NAME____ **DATE** ___________________________

Medical History

Are you taking any medications, pills or drugs? What? ____ Yes __ No__

Are you allergic to any medications or substances? Please check below ____

___ Aspirin ___Penicillin ___Codeine ___Acrylic ___Metal ___Latex Rubber ___Other ____________________________

Women (Please check) ___Pregnant/trying to get pregnant ___Nursing ___Taking Oral Contraceptives ___________Yes __No__

Do you now have or have you ever had any of the following? Please check appropriate boxes.
If yes to any of the starred conditions, pre-medication may be required.

Condition		Condition		Condition	
Heart Disease/Surgery*	__yes __no	Bruise Easily	__yes __no	Emphysema	__yes __no
Heart Murmur*	__yes __no	Anemia	__yes __no	Yellow Jaundice	__yes __no
Irregular Heart Beat	__yes __no	Excessive Bleeding	__yes __no	Cancer	__yes __no
Angina/Chest Pain	__yes __no	Sickle Cell Disease	__yes __no	X-ray Treatments	__yes __no
Heart Attack/Failure	__yes __no	Hemophilia	__yes __no	Chemotherapy	__yes __no
Congenital Heart Disorder	__yes __no	Leukemia	__yes __no	Aredia I.V	__yes __no
Mitral Valve Prolapse*	__yes __no	Blood Transfusion	__yes __no	Zometa I.V	__yes __no
Scarlet Fever	__yes __no	Swelling of limbs	__yes __no	Stomach Disease	__yes __no
Rheumatic Fever*	__yes __no	Lung Disease	__yes __no	Intestinal Disease	__yes __no
Artificial Heart Valve*	__yes __no	Breathing Problem	__yes __no	Ulcers	__yes __no
Heart Pace Maker*	__yes __no	Shortness of breath	__yes __no	Recent Weight Loss	__yes __no
Pulmonary Stunt	__yes __no	Frequent Cough	__yes __no	Frequent Diarrhea	__yes __no
High Blood Pressure	__yes __no	Hay Fever	__yes __no	Diabetes	__yes __no
Low Blood Pressure	__yes __no	Sinus Trouble	__yes __no	Excessive Thirst	__yes __no
Bacterial Endocarditis	__yes __no	Asthma	__yes __no	Hypoglycemia	__yes __no
Unexplained Fever	__yes __no	Bloody Sputum	__yes __no	Liver Disease	__yes __no
Hep A (infectious)	__yes __no	Night Sweats	__yes __no	Cold Sores	__yes __no
Hep B or C	__yes __no	Yellow Jaundice	__yes __no	Fever Blisters	__yes __no
Kidney Problems	__yes __no	Herpes	__yes __no	Renal Dialysis	__yes __no
Stroke	__yes __no	Thyroid Disease	__yes __no	Convulsions	__yes __no
Parathyroid Disease	__yes __no	Epilepsy/Seizures	__yes __no	Arthritus/Gout	__yes __no
Fainting and Dizziness	__yes __no	Rheumatism	__yes __no	Glaucoma	__yes __no
Pain in Jaw Joints	__yes __no	Tumor or Growth	__yes __no	Cortizone Medicine	__yes __no
Artificial Joint*	__yes __no	Psychiatric Care	__yes __no	Nervousness	__yes __no
Venereal Disease	__yes __no	Alzheimer's Disease	__yes __no	AIDS	__yes __no
Allergies (Medicines)	__yes __no	Allergies (other)	__yes __no	Hives or Rash	__yes __no
Genital Herpes	__yes __no	Drug Addiction	__yes __no	Alcoholism	__yes __no
Need Premedication?	__yes __no	Tattoos/Piercings	__yes __no	Ever taken fen-phen	__yes __no

Have you ever had any other serious illness not listed/checked above? Discuss ____

To the best of my knowledge, all the preceding answers are correct. If any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

Do you wish to talk to the dentist privately about any problem? ____

X____ Date____
Patient signature (parent or guardian)

Reviewed By Doctor ____ Date__________________ BP ____________________

Medical Updates

I have read my MEDICAL HISTORY dated ___________________ and confirm that it adequately states past and present conditions.

Date	Exceptions		Patients Signature	BP	Pulse	Reviewed By
______	__________________________	NONE_____	_______________	_____	_____	Dr _______________
______	__________________________	NONE_____	_______________	_____	_____	Dr _______________
______	__________________________	NONE_____	_______________	_____	_____	Dr _______________
______	__________________________	NONE_____	_______________	_____	_____	Dr _______________
______	__________________________	NONE_____	_______________	_____	_____	Dr _______________
______	__________________________	NONE_____	_______________	_____	_____	Dr _______________
______	__________________________	NONE_____	_______________	_____	_____	Dr _______________
______	__________________________	NONE_____	_______________	_____	_____	Dr _______________
______	__________________________	NONE_____	_______________	_____	_____	Dr _______________

FINANCIAL POLICY / HIPAA LAW

Thank you for choosing us for your dental care provider. Our office is committed to providing you with the highest quality dental care and personalized services. Please understand that payment for services is considered part of your treatment. The following is a statement of our Financial Policy that we require you to read and sign prior to any treatment. All patients must complete the required office forms and method of payment must be established before seeing the doctor.

Regarding payment
Payment is due at the time services are rendered unless prior arrangements have been made with the doctor.

If you have dental insurance, we will file your claim for you. If there is a balance after your insurance pays, we will send you a statement. After 60 days you are responsible for full payment on your account, regardless of your insurance company's coverage. (see below)

We accept the following forms of payment: Cash, check, Visa/MasterCard and CareCredit.

If dentures, partial dentures, crowns and bridges are to be fabricated by a dental laboratory, a deposit is due at the time of the first impression. The remaining balance is due at the time the prosthesis is cemented, inserted or delivered.

Checks that are returned to our office from your financial institution are subject to a $20 returned check fee. This fee covers the processing fees that are charged to our office.

Regarding Insurance
Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event we do accept assignment of benefits and your insurance company has not paid your account in full, the balance will be billed to you.

Please be aware that some, and perhaps all, of the services provided may not be non-covered services and not considered reasonable and customary under the terms of your insurance policy. Insurers' determination of usual and customary rates and coverage are generally arbitrary and not based on the usual and customary fees for our area. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of your insurance company's coverage. Please get a benefits booklet from you Human Resourses to help you understand your benefits.

Your complete insurance information must be presented at the time services are provided. Insurance claims cannot be backdated. Most benefits will be verified before your insurance company can be billed. We will need a copy of your dental insurance card in addition to identifying information such as the policy holder's social security number and insurance ID number in order to file the claim with your insurer as well as your Drivers Lic.

All insurance co-pays and deductibles must be paid at the time of service.

We will be happy to discuss our charges and how they relate to your particular situation. We also realize that temporary financial situations may affect timely payment of your account. If such problems arise, we encourage you to contact us promptly for assistance in the management of your account. In the event your account goes to a collection agency you will be responsible for fees incurred.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. I have read Apex Dental's Financial Policy. I understand and agree to this Financial Policy.

Signature of Patient or Responsible Party: ______________________________________Date: ____________

Printed Name of Patient or Responsible Party: ___________________________________

We request that our patients *call our office* at least 48 hours prior to their scheduled time to cancel an appointment. Appointments that are cancelled with less than 48 hours notice are considered a Broken Appointment and may be subject to a cancellation fee.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES (HIPAA)

I hereby acknowledge that I have access to Apex Dental's (Dr. Michael Harms') Notice of Privacy Practices.

Signature: ____ Date____________________