PATIENT REGISTRATION

First Name_____Last Name_____MI_____

Address_____

City, State & Zip Code_____

Home Phone#_____Work Phone#_____ext_____

Cell Phone#_____E-Mail Address_____

Birth Date_____Social Security#_____

Sex: Male_____ Female_____ Referred to our office by:_____

Marital Status: Married_____ Single_____ Divorced_____ Separated_____ Widowed_____

Responsible Party (if someone other than the patient)

First Name_____Last Name_____MI_____

Address_____

City, State & Zip Code_____

Home Phone#_____Work Phone#_____ext_____

Cell Phone#_____E-Mail Address_____

Birth Date_____Social Security#_____

Employment Status: Full-time_____ Part-time_____ Retired_____

Employer:_____Employer's address_____

Employer's ph# or Human Resource ph#_____

Student Status: Full-time_____ Part-time_____

Primary Insurance Information

Relationship to patient: Self_____ Spouse_____ Child_____ Other_____

Insurance company:_____

Address:_____

City, State & zip code_____

Waiver for Insurance coverage on fillings:

I, the undersigned, agree to allow Dr. Gardner and Winslow Dental to utilize esthetic, resin... composite (tooth colored) mercury free fillings in place of traditional silver amalgam fillings.

I understand that some insurance companies wish to limit my choices by paying only an amalgam fee. This means that it may cost me $30-$60 out of pocket expense per tooth to receive tooth colored fillings. I also understand that traditional amalgams contain a limited amount of mercury and I have discussed those possible health risks with my doctor.

ACCEPT_____ DECLINE_____

Signature_____Date_____

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, c

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?

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	Tonsilitis ◯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:_____

Privacy Practices Acknowledgement

Acknowledgement Form

I have received the *Notice of Privacy Practices* and I have provided an opportunity to review it.

Name: _____

Birth date: _____

Signature: _____

Date: _____

Patient Consent Form

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices.*

Winslow Dental L.L.C.
Brent J. Gardner D.D.S
321 west 2nd St.
Winslow, AZ 86047

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient
Name:_____

Signature:_____

Relationship to Patient:_____

Date:_____

WINSLOW DENTAL FINANCIAL AGREEMENT AND POLICIES

PAYMENT POLICY/INSURANCE SUBMISSIONS

Payment in full is required at the time of service for all past due balances, deductible amounts that have not been met, non-insured patients and any coverage that could not be verified at the time of service. As the parent/or guardian you are required to pay the co-pay/coinsurance at the time of service. Claims are submitted to the insurance carrier as a courtesy; however, you are responsible for payment of all charges incurred. All balances not paid by the insurance carrier within 90 days of the date of service will be your responsibility. We will be happy to reimburse you for any payments made by you after your insurance has paid in full.

PLEASE NOTE: IF YOU HAVE CHANGES TO YOUR INSURANCE INFORMATION, PLEASE NOTIFY OUR OFFICE IMMEDIATELY. WINSLOW DENTAL WILL NOT BE RESPONSIBLE FOR TIMELY FILING DENIALS IF WE DO NOT RECEIVE THE CORRECT INSURANCE INFORMATON PRIOR TO OR AT THE TIME OF VISIT.

_____**Initial-I have read and agree to the Payment Policy Statement**

RETURNED CHECKS

All Checks returned for insufficient funds, closed accounts, or any other reason, will be subject to a $32 service charge. The service charge and the amount of the check must be paid in full within 15 working days. Please be advised that failure to contact us and/or make the above payment may result in your check being forwarded to the Navajo county Attorney's Bad Check Program.

_____**Initial- I have read and agree to the Returned Check Policy Statement**

PAST DUE BALANCES AND COLLECTION FEE'S

We will require all balances over 90 days from the date of service to be paid in full before any further routine services are rendered regardless of whether or not there is insurance coverage. We are more than happy to assist you in resolving balance and payment issues. Payment arrangements must be made with the Financial Coordinator and will not be accepted until the office receives the signed payment agreement. Balances not paid over 90 days or failure to comply with prior payment arrangements are subject to collection, legal action, and dismissal from the practice. If your account is referred to collections or legal services, you will be responsible for any collection or legal fees. **YOU AGREE TO REIMBURSE US THE FEES OF ANY COLLECTION AGENCY, WHICH MAY BE BASED ON A PERCENTAGE AT A MAXIMUM OF 35% OF THE DEBT, AND ALL COSTS, AND EXPENSES, INCLUDING REASONABLY ATTORNEYS' FEES, WE INCUR IN SUCH COLLECTION EFFORTS.**

_____**Initial- I have read and agree to the Past due balance and collection fee's Statement**

DIVORCE/ CUSTODY

The parent and/or legal guardian who brings in the child for dental services will be required to pay the bill. We do not bill third parties regardless of what the decree or custody documents indicate. Please make the appropriate arrangements prior to the office visit.

_____**Initial- I have read and agree to the Divorce/Custody Statement**

NO SHOW/ CANCELLED APPOINTMENTS

All appointments require at least 24 hour prior notification of cancellation. No shows or appointments cancelled with less that 24 hour notice will be subject to the following charges.

APPOINTMENT	FEE
1st Encounter	WAIVED
2nd Encounter	WARNING
3rd Encounter	$50.00 FEE

_____**Initial- I have read and understand the No Show/ Cancellation Statement**

INSURANCE AUTHORIZATION

I authorize Winslow Dental to release any dental or other information to the insurance carrier which may be necessary to process the claims. I authorize my insurance carrier to pay the provider for services. In the event that payment is made to the policy holder, I agree to submit payment to Winslow Dental.

_____

PATIENT/PARENT OR LEGAL GUARDIAN SIGNATURE **DATE**