

Patient Registration

Please complete registration in its entirety. Have your insurance cards and driver's license available for scanning purposes.

Mr. Mrs. Miss Ms. Dr.

PATIENT NAME _____
Last First Middle Maiden

PREFERRED NAME _____ BIRTH DATE (Month/Date/Year) _____

MALE FEMALE PATIENT'S S.S.# _____

PRIMARY LANGUAGE: _____ DO YOU NEED AN INTERPRETER? Yes No

MARITAL STATUS SINGLE MARRIED DIVORCED OTHER _____

HOME ADDRESS _____ APT NO. _____

CITY _____ STATE _____ ZIP _____

HOME PHONE (_____) _____ CELL PHONE (_____) _____

WORK PHONE (_____) _____ PREFERRED CONTACT # Home Cell Work

EMAIL ADDRESS _____ MAY WE EMAIL YOU? Yes No

STUDENT Yes No WHERE? _____ Full Time Part Time

OSU STUDENT I.D. # (if applicable): _____ DRIVER'S LICENSE #: _____

PATIENT'S EMPLOYER _____ MAY YOU BE CONTACTED AT WORK? Yes No

OSU EMPLOYEE I.D. # (if applicable) _____

EMERGENCY CONTACT

Name: _____

Relationship to patient: _____ Phone: _____

PRIMARY CARE PHYSICIAN _____
First Name Last Name Telephone Number

PHARMACY NAME/LOCATION _____
Telephone Number

Do you have family members who are patients of our practice? Yes No

If yes, name of patient(s) _____

Patient Signature: _____ Date: _____

If patient is a minor, parent's signature

Insurance Information

Please complete all applicable information and have your insurance card(s) available for our office to scan.

Primary Dental Insurance

I DO NOT HAVE DENTAL INSURANCE AT THIS TIME

Insurance Co. Name		Subscriber Name	
Insurance Tel. #		Subscriber Birth Date	
Insurance P.O. Box		Subscriber S.S. #	
Employer Name		Identification #	
Employer Tel. #		Group #	

Relationship to patient: Self Spouse Parent Guardian Subscriber Sex: Male Female

Marital Status: Single Married Divorced Other _____ Subscriber address same as patient's Yes No

Secondary Dental Insurance

I DO NOT HAVE SECONDARY DENTAL COVERAGE

Insurance Co. Name		Subscriber Name	
Insurance Tel. #		Subscriber Birth Date	
Insurance P.O. Box		Subscriber S.S. #	
Employer Name		Identification #	
Employer Tel. #		Group #	

Relationship to patient: Self Spouse Parent Guardian Subscriber Sex: Male Female

Marital Status: Single Married Divorced Other _____ Subscriber address same as patient's Yes No

Subscriber's address if different than patient's: _____

COMPLETE THIS SECTION IF YOUR VISIT IS MEDICAL IN NATURE. Otherwise, please skip to Adult Medical History.

Medical visit examples: oral surgery, oral pathology, or related to an accident.

Primary Medical Insurance

I DO NOT HAVE MEDICAL COVERAGE AT THIS TIME

Insurance Co. Name		Subscriber Name	
Insurance Tel. #		Subscriber Birth Date	
Insurance P.O. Box		Subscriber S.S. #	
Employer Name		Identification #	
Employer Tel. #		Group #	

Relationship to patient: Self Spouse Parent Guardian Subscriber Sex: Male Female

Marital Status: Single Married Divorced Other _____ Subscriber address same as patient's Yes No

Secondary Medical Insurance

I DO NOT HAVE SECONDARY MEDICAL COVERAGE

Insurance Co. Name		Subscriber Name	
Insurance Tel. #		Subscriber Birth Date	
Insurance P.O. Box		Subscriber S.S. #	
Employer Name		Identification #	
Employer Tel. #		Group #	

Relationship to patient: Self Spouse Parent Guardian Subscriber Sex: Male Female

Marital Status: Single Married Divorced Other _____ Subscriber address same as patient's Yes No

Subscriber's address if different than patient's: _____

****END OF MEDICAL SECTION****

For Office Use Only:

EMR #: _____

Adult Medical History

Patient Name: _____ **Date of Birth:** _____ Today's Date _____
Last *First* *M.I.*

Y	N	General
		Height _____ ft _____ in
		Weight _____ lbs
		General health status (choose one): <div style="text-align: center; margin-top: 5px;"> Excellent Good Fair Poor </div>
		Are you under physician's care?
		Have you been hospitalized in the past 10 years?
		Have you had any emergency room visits in the past 10 years?
		Has your doctor limited your activity?
		Can you climb two flights of stairs without rest?
Please mark "yes" or "no" for any conditions that you have now, or have had in the past		
Y	N	CARDIOVASCULAR / HEMATOLOGIC
		Do you have any heart, circulatory or blood pressure conditions?
		Heart attack (mi)
		Congestive heart failure (chf)
		Angina (chest pain)
		Heart surgery / stent / valve replacement
		Hypertension (high blood pressure) <div style="margin-top: 5px;"> If yes, what is your usual blood pressure? _____ </div>
		Arrhythmia
		Pacemaker/ICD
		Other heart conditions:
Y	N	PULMONARY
		Do you have any lung or breathing conditions?
		Asthma
		Chronic obstructive pulmonary disease (COPD)
		Other lung or breathing conditions:

Y	N	NERVOUS SYSTEM
		Do you have any nervous system conditions?
		Seizures - if yes , please choose which type: <div style="text-align: center; margin-top: 5px;"> Absence Grand mal Petit mal Other </div>
		Stroke/TIA - if yes , please choose which type: <div style="text-align: center; margin-top: 5px;"> Hemorrhagic Occlusive </div>
		Syncope (fainting)
		Other neurological (nerve) conditions?
Y	N	GASTROINTESTINAL / LIVER / BLOOD / METABOLIC
		Do you have any gastrointestinal, liver, blood or metabolic Conditions?
		Hepatic (liver) disease
		Hepatitis
		Renal (kidney) disease
		Unusual bleeding
		Sickle cell anemia / trait
		Diabetes - if yes , please choose which type: I II
		Gastrointestinal (g.i.) Disease or condition
		Thyroid disease
Y	N	INFECTIOUS DISEASES
		Do you have any infectious diseases?
		Tuberculosis (tb)
		Hiv /AIDS viral load _____ cd4 count _____
		Hepatitis B
		Other infectious or immune conditions: _____
Y	N	ORTHOPEDIC / MUSCULOSKELETAL
		Do you have any orthopedic or musculoskeletal disease?
		Bone problems or diseases (osteoporosis, others)
		Artificial joints
		Arthritis - if yes , please choose which type: <div style="text-align: center; margin-top: 5px;"> Osteoarthritis Rheumatoid Arthritis Other </div>
		Muscle problems or diseases _____
		Jaw or jaw joint problems (TMD)

Y	N	OTHER
		Do you have any other medical conditions?
		Pregnant or nursing If pregnant, expected delivery date _____
		Cancer and cancer treatment If yes, what type/location _____
		Emotional/psychiatric disorders _____
		Frequent sinus infections (sinusitis)
		Sleep apnea
		Do you have the symptoms below? Snore loudly Often tired, fatigued, or sleepy Observed to stop breathing or choke/gasp in your sleep Being treated for high blood pressure Neck size (shirt collar) over 17" (men) or 16" (women)

Y	N	SOCIAL
		Have you ever consumed alcohol or used recreational drugs?
		Do you consume alcoholic beverages? If yes..... How many times in the past year have you had 4 (women), 5 (men) or more drinks in a single day? _____
		Do you use recreational drugs?
		Have you ever smoked cigarettes? For how many years? _____ How many packs per day? _____
		Are you a former smoker? If yes, when did you quit? Month _____ Year _____
		Have you ever used tobacco (other than cigarettes)? If yes, what type? _____
		Do you use electronic cigarettes?
		Do you have problems or conditions not listed above? _____
		Do you have a condition requiring accommodation?

MEDICATIONS AND ALLERGIES

List any current or recent medications you take:

Allergies or reactions to any medicines?

Medication name: _____ Reaction: _____

Medication name: _____ Reaction: _____

Medication name: _____ Reaction: _____

Medication name: _____ Reaction: _____

I certify that the above information is complete and accurate to the best of my knowledge. I understand that providing incomplete or inaccurate information may negatively influence my treatment and my treatment results.

Your signature: _____

Patient Name:

Date of Birth:

Please Read Each Paragraph and Initial

Insurance Verification/Release/Authorization/Assignment

I certify that the information pertaining to my active dental and/or medical insurance coverage is correct.

I authorize the release of any dental/medical records or other information, including the diagnosis and treatment rendered to me, as requested by my dental and/or medical insurance carrier. I am aware this may include information regarding HIV or AIDS, alcohol or drug abuse and psychiatric treatment.

I request and assign benefit payment(s) from my insurance carrier(s) directly to the Dental Faculty Practice and to the practitioner who rendered my service.

Financial Responsibility

I understand that payment is expected in full prior to the services being rendered for patients who do not have dental or medical insurance (if applicable) coverage.

I understand that should I arrive on the day of my appointment with no means of payment, the Dental Faculty Practice reserves the right to reschedule my appointment.

Missed or Broken appointments (if less than 24 hours' notice) may have a fee assessed at the provider's discretion and this fee is the patient's responsibility.

Patients who have verified dental (and/or medical, if applicable) insurance benefits

I understand that the financial obligation for any services rendered/received is my responsibility and not the responsibility of the Dental Faculty Practice, my provider of service or my insurance carrier. I understand that the Dental Faculty Practice will make reasonable effort on my behalf to obtain all applicable benefits from my insurance carrier(s), but there is no promise or guarantee of payment/coverage. Any balance due after insurance processing and/or insurance payment received is my responsibility. *****Note** Account balance is due 60 days from the date of service, whether payment has been received from your insurance carrier or not.***

I understand that my Dental Faculty Practice provider may not be an "in-network" provider with my medical and/or dental insurance carrier and services/procedures may be subject to out-of-network deductibles, allowables and co-payments.

Co-payment, deductible and deposit (in some cases) is payable prior to the services being rendered. A predetermination of dental benefits may be submitted (time permitting) prior to initiation of treatment in order to obtain the estimated patient out-of-pocket expense. If you would like a predetermination of dental benefits, please contact the insurance/financial department.

Account balances must remain in good standing to avoid collection proceedings. Payment contracts/arrangements must follow agreed upon guidelines. Past due account balances (90+ days) will be forwarded to our collection agency.

Payment Options

- Cash, check, MasterCard, Visa, Discover, American Express or debit cards are acceptable.
- H.S.A. (if applicable) and Flexible Spending benefit cards or checks are acceptable.
- Care Credit - For those patients who prefer to extend payments beyond the conclusion of treatment. We are pleased to offer Care Credit; the American Dental Association's approved commercial line of credit, specifically designed for the payment of dental care. To learn more about Care Credit, feel free to speak to the insurance/financial department.

*****NOTE** A NSF fee of \$34 will be charged for returned checks***

****PLEASE NOTE**** - **Divorced Parents:** *The parent who is present with the patient at time of appointment will be considered the "financially responsible party" and will be accountable for all fees incurred.*

MEDICAID PATIENTS I understand I must submit my current Medicaid identification card on the day service is rendered. I also understand after Medicaid has processed the claim there may be a portion of the balance which will be my responsibility. I agree to pay this balance within 30 days.

MEDICARE PATIENTS I understand that Medicare rarely covers dental procedures and I am responsible for the full fee associated with such services. I understand that after Medicare processes my claim, any balance due is my responsibility. I agree to pay this balance within 30 days.

BWC/TRAUMA/ACCIDENT PATIENTS I understand that it is my responsibility to notify the insurance department that I am being treated as a result of an injury **prior to** any services being performed. A treatment coordinator from the insurance/financial department will be assigned to my case to work with me in regard to insurance/financial matters.

FINANCIAL RESPONSIBILITY / WHO WILL BE RESPONSIBLE FOR THIS ACCOUNT?

PATIENT IS RESPONSIBLE PARTY

RESPONSIBLE PARTY INFORMATION (Complete if patient is not Responsible Party)

NAME **RELATIONSHIP** **Spouse** **Parent** **Other**

DATE OF BIRTH **SOCIAL SECURITY #**

HOME PHONE **CELL PHONE**

HOME ADDRESS **STREET**

CITY **STATE** **ZIP**

EMPLOYER **PHONE**

ALTERNATE CONTACT (CLOSEST RELATIVE WHO DOES NOT LIVE WITH YOU)

NAME **RELATIONSHIP** **PHONE #**

By signing below I verify that I have read, understand and accept the guidelines and terms stated within the Dental Faculty Practice Initial Consent for Treatment, Insurance Release/Authorization/Assignment and Financial Responsibility form and that I am the financially responsible party for this patient's account.

Print Name of Responsible Party

Signature

Date

PATIENT DISCLOSURE INSTRUCTIONS

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means. This would include mailing correspondence to the individual's office instead of the individual's home, emailing correspondence (via secure email server) and/or the use of text messaging systems.

I wish to be contacted in the following manner (*check all that apply*):

Home Phone (_____) _____

- O.K. to leave message with detailed information
- Leave message with callback number only

Written Communication - U.S. Mail/Fax

- O.K. to mail to my home address
- O.K. to mail to my work/office address
- O.K. to fax to number indicated below

Fax # (_____) _____

Cell Phone (_____) _____

- O.K. to leave message with detailed information
- Leave message with callback number only
- O.K. to text appointment information
- O.K. to text account/financial information

Written Communication - E-mail (via secure email server)

- O.K. to email appointment information
- O.K. to email account/financial information

Email Address:

Work Phone (_____) _____

- O.K. to leave message with detailed information
- Leave message with callback number only

I hereby grant permission for Dental Faculty Practice providers and/or representatives to share clinical and financial information with or answer questions from (*check all that apply and print name or names*):

Spouse _____

Parent _____

Child _____

Other (name and specify relationship): _____

Direct patient contact only

Patient or Guardian Signature

Print Name of Patient or Guardian

Date Signed