PATIENT REGISTRATION FORM

Today's Date ____________________

PATIENT REGISTRATION

Patient Name	Nick Name	Birthdate	Sex M F
Address	Zip Code	Phone	
Employer	Business Address	Phone	
Yrs. Employed	Soc. Sec. No.	Marital Status: S M D W	
Spouse Name	No. of Dependents	Spouse's Soc. Sec. No.	
Spouse's Employer	Referred By		
Emergency Contact Name	Phone		

PERSON RESPONSIBLE FOR THIS ACCOUNT

Responsible Party's Name		Relationship to Patient
Street Address		Phone
Employer	Years Employed	Soc. Sec. No.
Business Address		Phone

FOR PATIENTS COVERED BY INSURANCE

Subscriber's Name	Employee I.D. #	Birthdate	Soc. Sec. No.
Employer	Business Address		Insurance Co.
Group No.	Deductible Met? Yes No	Max. Benefit $_____	Benefit Year

Patient's Relation to Subscriber: Self Spouse Dependent Have You Used Your Dental Insurance This Benefit Year? Yes No

Are You Covered Under More Than One Dental Plan? Yes No _If Yes, Please Fill Out Next Section_

SECONDARY INSURANCE

Subscriber's Name	Employee I.D. #	Birthdate	Soc. Sec. No.
Employer	Group No.	Insurance Co.	Relationship to Patient

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Primary Subscriber's Name	Family Member No.	Emp. No.
Secondary Subscriber's Name	Family Member No.	Emp. No.
Doctor		

Medical Message

1 No Message 2 See Medical 3 Pre-medicate 4 See Medical and Pre-medicate 5 Allergies

The above information is accurate and complete and to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient or Responsible Party ______________________ Date ____________

2-561-312-01 6.29.92

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HEALTH HISTORY

Patient Name ______________________________ Date ______________

Have you been or are you now under a physician's care? .... Yes No

If yes, why? .... Yes No

Have you ever been hospitalized? .... Yes No

Reason: ______________________________

Physician's Name: ______________________________

When was your last complete physical? ______________________________

Are you currently taking any medications? .... Yes No

List: ______________________________

Have you taken any cortisone/had steroid therapy during the past two years? .... Yes No

Are you allergic to or have any adverse reaction to any of the following medications:

Aspirin	Codeine	Penicillin
Erythromycin	Local Anesthetic	Nitrous Oxide

Are you aware of being allergic to any other medications? .... Yes No

If yes, please list: ______________________________

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

Artificial Joint	Yes	No
Heart Valve Implant	Yes	No
Heart Disease/Attack	Yes	No
Rheumatic Fever	Yes	No
Heart Murmur	Yes	No
High/Low Blood Pressure	Yes	No
Pacemaker	Yes	No
Allergies/Asthma	Yes	No
Sinus Problems	Yes	No
Epilepsy/seizures	Yes	No
Fainting/Dizzy Spells	Yes	No
Psychiatric Treatment	Yes	No
Glaucoma	Yes	No
Diabetes	Yes	No
Eating Disorder	Yes	No
Circulatory Problems	Yes	No
Excessive Bleeding From Cut/Injury	Yes	No
Anemia	Yes	No
Blood Transfusion	Yes	No
Hepatitis/Jaundice/Liver Disease	Yes	No
Tuberculosis	Yes	No
AIDS/HIV Exposure	Yes	No
Venereal Disease	Yes	No
Alcoholism/Drug Abuse	Yes	No
Radiation Treatment	Yes	No
Cancer/Tumor	Yes	No
Chemotherapy	Yes	No
Malignant Hyperthermia/Family History	Yes	No
Ulcers	Yes	No
Nervous Problems	Yes	No
Recent Weight Loss	Yes	No
Blood Diseases	Yes	No
Arthritis	Yes	No
Stroke	Yes	No

Do you smoke or chew tobacco? .... Yes No

How much? ______________________________

Do you consume alcoholic beverages? .... Yes No

How often? ______________________________

Are you pregnant or suspect you may be? .... Yes No

Are you nursing? .... Yes No

Are you taking oral contraceptives? .... Yes No

Do you wear contact leases? .... Yes No

Do you have any disease, condition or problem not listed? .... Yes No

To the very best of my knowledge, the above information is true.

Patient Signature ______________________________ Date ______________

Staff Signature ______________________________ Dr. Initial ______________

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CONFIDENTIAL NEW PATIENT QUESTIONNAIRE

Please answer the questions below so that we may serve you better. Thank you for your assistance, we look forward to helping you.

1. When was your last exam? ____
2. When was your last cleaning? _____________________________________
3. Are you having any pain or discomfort at this time? Yes or No
4. Do your gums bleed when you brush? Yes or No
5. Are you happy with your smile? Yes or No
6. Are you interested in whitening your teeth? Yes or No
7. Are you interested in straightening your teeth? Yes or No
8. Are you interested in invisible braces? Yes or No
9. Have you been told you grind your teeth at night? Yes or No
10. Have you been told you snore at night? Yes or No
11. Have you been diagnosed with TMJ (jaw) problems? Yes or No
12. Are you concerned with bad breath? Yes or No
13. Are you frequently experiencing dry mouth? Yes or No

FINANCIAL POLICY

The purpose of this form is to avert any potential misunderstandings. We want our patients to feel free to discuss our fees and their personal dental needs. We encourage communication, and base our services on a friendly mutual understanding between the patient and our office. We feel everyone benefits when definite financial arrangements are agreed upon prior to treatment. All fees are due at the time of service unless prior arrangements have been made. We gladly accept: MasterCard, Visa, Discover, American Express, and Care Credit.(Care Credit is a third party source of financing your dental care, please ask staff for details if you are interested.)

INSURANCE: We file your primary insurance for you as a courtesy. We require insurance patients to pay their estimated share at the time of service. We do not accept secondary insurance payments toward your share. We will help you file your secondary insurance, but have found it takes 3 to 6 months for secondary plans to pay, if at all. There are hundreds of different policies existing and we can not know the finite details of your policy. Your insurance is a contract between you and your insurance company. We do not have any control over the details of your plan. We will do everything in our power to help you receive your dental benefits. **Please be aware that any part of your bill that is not paid within 60 days of the date of service is due immediately by you.** Please sign both areas below if you want us to file your insurance for you.

I authorize release of any information relating to this claim. I understand I am responsible for all costs of dental treatment.

______________________________ ______________________

Signed-Patient (or Parent/Guardian of minors) Date

I hereby authorize payment directly to W. Michael Copeland DDS of the group insurance benefits otherwise payable to me.

______________________________ ______________________

Signed-Patient (or Parent/Guardian of minors) Date

OVERDUE ACCOUNTS: Please be advised that all balances over 30 days past due are subject to interest charges (1.5%) per month. **Balances over 90 days past due are subject to late fees, interest charges, and the patient is responsible for collection costs (40% fee charged by the collection agency).**

BROKEN APPOINTMENTS: Appointment times are reserved exclusively for you. We do not double book. Time lost is costly to everyone. We reserve the right to charge for broken appointments (less than two working days notice). Messages left on the recorder are not considered until 8 a.m. of the next working day. Broken appointment charge: $30/hr.

Thank you for your cooperation, and we look forward to a mutually satisfying relationship. Please feel free to discuss your particular needs with the staff. Sincerely,

W. Michael Copeland DDS

I have read the above and agree to the terms.

______________________________ ______________________

Signed- Patient (or Parent/Guardian of minors) Date

W. Michael Copeland DDS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, ______________________________, have received a copy of this office's Notice of Privacy Practices.

____
{Please Print Name}

____
{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

☐ Communications barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please Specify)

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