HICKS DENTAL GROUP

PATIENT REGISTRATION

ID: _____ Chart ID: _____

First Name: _____ Last Name: _____ Middle Initial: ____

Patient Is: ☐ Policy Holder Preferred Name: _____

☐ Responsible Party

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: ____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

○ Responsible Party is also a Policy Holder for Patient ○ Primary Insurance Policy Holder ○ Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ State / Zip: _____ _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ○ Male ○ Female Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic: _____

E-mail: _____ ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ○ Full Time ○ Part Time ○ Retired

Student Status: ○ Full Time ○ Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

Section 3

emergency contact: _____

home phone: _____

other phone: _____

relation to patient: _____

referred by: _____

Physicians Name : _____

Physicians phone# : _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

HICKS DENTAL GROUP

Medical History

PATIENT NAME _____ Birth Date _____

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, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ○ Yes ○ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ○ Yes ○ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ○ Yes ○ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ○ Yes ○ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ○ Yes ○ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ○ Yes ○ No _____
Are you on a special diet? ○ Yes ○ No
Do you use tobacco? ○ Yes ○ No
Do you use controlled substances? ○ Yes ○ No

Women: Are you
Pregnant/Trying to get pregnant? ○ Yes ○ No Taking oral contraceptives? ○ Yes ○ No Nursing? ○ Yes ○ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

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 Problem ○ 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	Tonsillitis ○ 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 _____

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 _____ DATE _____

HICKS DENTAL GROUP

UNDERSTANDING OFFICE POLICY AND INSURANCE RESPONSIBILITIES:

First and most important, we are pleased you have chosen us to care for your dental health. Our goal is to provide the best dental care possible.

It is important we are "up front" with each other as to what our mutual responsibilities are.

OUR PAYMENT POLICIES:

We accept the following forms of payment: cash, check, credit and debit cards. FULL PAYMENT IS DUE AT THE TIME THAT SERVICES ARE RENDERED, unless we are billing your insurance company or prior arrangements have been made. Please understand that you, the client or other responsible party are liable for all charges and balances on your account. There will be a $30.00 fee charged for all returned checks, plus the face value of the check. Should it be necessary to refer your account to collections, you agree to pay all the collection costs involved including attorney fees.

If we are contracted with your insurance company, we will honor all of our provisions of that contract. To do this, however, we need your help. If you have changed companies and policies, we must be advised prior to the date we provide service, and give current insurance identification cards and addresses for insurance submission. Otherwise, insurance benefits may be denied or delayed by your insurance company and you there by, immediately become financially responsible for the provided services.

My signature indicates I understand all of the above and I agree to abide by the agreement.

Signature_____Date_____

WE WILL PROCESS YOUR CLAIM AS A COURTESY TO YOU based on the information provided to us by you and your insurance company. You need to be familiar with your policy coverage, benefits, and eligibility.

Deductible amount and fees for non-covered services as determined by your insurance company are the financial responsibility of you, as well as unpaid claims due to lapse or termination of coverage, or delayed payments if incorrect information is provided, or if your insurance company does not process your claims within 30 days.

January 1, 2012, you are responsible for payment after your primary insurance pays. As a courtesy to you, we will still submit primary and secondary insurance and have the secondary insurance pay you directly.

Your insurance policy is a contract between you and your insurance company. We cannot guarantee that your insurance company will pay your claim. You are responsible for payment of your account in full at the end of 30 days after date of service.

I understand that I am financially responsible for the charges not covered by my insurance. I hereby authorize Hicks Dental Group to release any information acquired in the course of my examination and treatment to my insurance company upon their request.

I authorize assignment of benefits from my insurance to be paid directly to Hicks Dental Group.

Signature_____ Date_____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY POLICY RIGHTS

I have been made aware of Hicks Dental Group privacy rights policy.

X Signature **Date:**

Print name: **Relationship to Patient**

HICKS DENTAL GROUP

GETTING TO KNOW YOU

Name:_____

Occupation_____

Hobbies/Intrest_____

Reason for changing dentists and/or reason for your visit today: _____

_____

When was your last cleaning and/or dental appointment?_____

Have you ever had a deep cleaning or periodontal maintenance? Yes ☐ No ☐

How often do you brush?_____ How often do you floss?_____

Have you had any problems with past dental treatment?

Not at all! **1 2 3 4 5** *A lot! Why?*_____

Is there anything we could do to make your visit more comfortable?

_____

On a scale from 1 to 5 how important is oral health and hygiene in your life:

Not at all **1 2 3 4 5** *A lot! Why?*_____

Do your gums bleed when brushing/flossing? *If so where?*_____

Do you clench or grind your teeth? Yes ☐ No ☐ I Don't Know ☐

Have you had or do you currently have pain/discomfort in your jaw joints?_____

Do you like your smile? ☐ Yes No ☐

Is there anything you would change about it?_____

Are you currently having any pain, problems, or concerns that you would like to discuss?_____