Hushmail

Patient Registration Form

Patient Information

First Name *

Middle Initial *

Last Name *

Preferred Name

Home Address *

City *

State *

ZIP Code *

Is your billing address the same as your home address? *

Yes

No

Cell Phone *

Home Phone

Email address *

Birthdate *

Gender *

Please select

Marital Status *

Please select

Emergency Contact Name *

Emergency Contact Phone *

123-456-7890

Previous Dental Office / Dentist

Date Last Seen (Approx.)

Previous Dentist Phone Number

123-456-7890

Do you currently have any tooth discomfort?

Yes No

Are you happy with the function and appearance of your teeth?

Yes No

Do your gums bleed when you brush your teeth?

Yes No

Have you ever been told you have gum disease?

Yes No

Recommended Hygiene Interval?

3 Months 4 Months

6 Months

Radiographs (X-Rays)

Dental X-rays are an important tool that are used to detect problems that are not visible during a regular dental exam, such as cavities between teeth, bone loss, impacted teeth, and abscesses. We use the latest digital radiography to safely and comfortably take a series of x-rays.

It is of utmost importance that your prior dental x-rays, are in our office before your new examination by Dr. Goding. If no x-rays are received, please be prepared for our staff to take new x-rays, which may be at your expense. It is your responsibility to ensure we receive the x-rays.

To avoid cancellation or rescheduling of your appointment, the completed New Patient Forms and prior x-rays MUST be in our office before your scheduled appointment. We encourage you to contact your previous dental office regarding the timely transfer of your x-rays to our office.

Please complete the information in the section below and request x-rays be emailed to our office at info@pinelanddentistry.com. If no x-rays are available, please check "None Available." Note: You will be redirected to our Release of Records form after completing this

- [ ] FMX
- [ ] PAN
- [ ] Bitewings
- [ ] None Available
- [ ] Requested Prior Dental Office to Email Above Radiographs to info@pinelanddentistry.com

How did you hear about us?

- [ ] Patient
- [ ] Website
- [ ] Google
- [ ] Other

Responsible Party

Are you responsible for payment for services provided? *

Yes No

Dental Insurance Information

Please verify the information provided below is DENTAL insurance NOT health insurance. If you do not have the information below, please call your insurance company as we will need this information to process your claims.

☐ No Insurance - Self Pay

Name Of Policy Holder *

Relation to Policy Holder *

Choose One

☐ Group Dental Plan Name of Employer

OR

☐ Individual Dental Plan

Insurance Company *

Group # *

Policy Holder's ID or Social Security Number (IMPORTANT!) *

Some insurance companies use your social security as your member ID

Insurance Claims Mailing Address *

Insurance Phone *

City *

State *

Zip *

*** Information located on the back of your insurance card - Please be sure to bring your card to your appointment.**

Medical History

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

Have you ever been hospitalized or had a major operation?

Yes No

Have you ever had a serious head or neck injury?

Yes No

Are you taking any medication, pills, or drugs?

Yes No

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

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
- [ ] Codeine
- [ ] Acrylic
- [ ] Latex
- [ ] Penicillin
- [ ] Local Anesthetics
- [ ] Metal
- [ ] Sulfa Drugs
- [ ] Others Allergies

Do you have, or have had, any of the following?

AIDS/HIV Positive	Alzheimer's Disease	Anaphylaxis
Yes No	Yes No	Yes No
Anemia	Angina	Arthritis/Gout
Yes No	Yes No	Yes No
Artificial Heart Valve	Artificial Joint	Asthma
Yes No	Yes No	Yes No
Blood Disease	Blood Transfusion	Breathing Problem
Yes No	Yes No	Yes No
Bruise Easily	Cancer	Chemotherapy
Yes No	Yes No	Yes No
Chest Pains	Cold Sores/Fever Blisters	Congenital Heart Disorder
Yes No	Yes No	Yes No
Convulsions	Cortisone Medicine	Diabetes

Yes No

Yes No

Yes No

Drug Addiction

Easily Winded

Emphysema

Yes No

Yes No

Yes No

Epilepsy or Seizures

Excessive Bleeding

Excessive Thirst

Yes No

Yes No

Yes No

Fainting Spells/Dizziness

Frequent Cough

Frequent Diarrhea

Yes No

Yes No

Yes No

Frequent Headaches

Genital Herpes

Glaucoma

Yes No

Yes No

Yes No

Hay Fever

Heart Attack/Failure

Heart Murmur

Yes No

Yes No

Yes No

Heart Pacemaker

Heart Trouble/Disease

Hemophilia

Yes No

Yes No

Yes No

Hepatitis A

Hepatitis B or C

Herpes

Yes No

Yes No

Yes No

High Blood Pressure

High Cholesterol

Hives or Rash

Yes No

Yes No

Yes No

Hypoglycemia

Irregular Heartbeat

Kidney Problems

Yes No

Yes No

Yes No

Leukemia

Liver Disease

Low Blood Pressure

Yes No

Yes No

Yes No

Lung Disease

Mitral Valve Prolapse

Osteoporosis

Yes No

Yes No

Yes No

Pain in Jaw Joints

Parathyroid Disease

Psychiatric Care

Yes No

Yes No

Yes No

Radiation Treatments

Recent Weight Loss

Renal Dialysis

Yes No

Yes No

Yes No

Rheumatic Fever

Rheumatism

Scarlet Fever

Yes No Yes No Yes No

Shingles Sickle Cell Disease Sinus Trouble

Yes No Yes No Yes No

Spina Bifida Stomach/Intestinal Disease Stroke

Yes No Yes No Yes No

Swelling of Limbs Thyroid Disease Tonsillitis

Yes No Yes No Yes No

Tuberculosis Tumors or Growths Ulcers

Yes No Yes No Yes No

Venereal Disease Venereal Disease

Yes No Yes No

Have you ever had any serious illness not listed above?

Yes No

Comments

Medical History Confirmation

- [ ] 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. *

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: (1) conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly; (2) obtain payment from third-party payers and (3) conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. 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 to obtain a current copy of the Notice of Privacy Practices.

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 that you are not required to agree to my restrictions, but if you do agree then you are bound to abide by such restrictions.

Financial Policy Acknowledgement

We are committed to providing you with the best possible dental care. Our fees reflect our professional commitment to excellence. In order to achieve these goals, we need your assistance and understanding of our financial policy.

For the convenience of our patients, we offer the following methods of payment: (1) payment in full by cash or check, (2) Visa, Mastercard, & Discover and (3) Care Credit, a third-party financing company, which offers interest-free payment plans.

If you have dental insurance, we are happy to help you receive your maximum allowable benefits. **However, it is important for you to realize the following:**

(1) your dental insurance policy is a contract between your employer and the dental insurance carrier. Pineland Family Dentistry is not a part of that contract.

(2) While we are happy to investigate your insurance benefits and file claims on your behalf, you are ultimately responsible for understanding your insurance benefits prior to treatment.

(3) We do accept the assignment of benefits from your insurance which authorizes your insurance company to issue payment directly to Pineland Family Dentistry on your behalf.

(4) Prior to any treatment, you will be provided with an *estimate* of how much we expect the insurance to pay and how much your *anticipated* out of pocket will be. We will collect your anticipated out of pocket expense at the time of service.

(5)Balances due to insurance denials are the patient's responsibility regardless of the reason for the denial.

(6) If the insurance company does not pay for your treatment in a reasonable period of time, (more than two months), the patient is responsible for paying the remaining balance. All credits, if any, will be returned to the patient upon receipt of payment from the insurance company.

(7) Please be aware that when bringing in a minor for treatment, the parent or guardian

bringing the child in is responsible for any payment due for the child that day.

Financial Charges: All returned checks are subject to a $35.00 fee.

Past Due Accounts: Account balances over 60 days are subject to a $20 billing fee and a 1.5% finance charge.

Reserved Appointment Policy

We greatly value you and your commitment to excellent dental health. In order to care for you effectively, we ask that you pre-schedule your next preventative visit prior to leaving the office to ensure that you stay on track with your necessary dental treatment. These semi-annual or quarterly “cleanings” will help to prevent the need for further, more invasive, and costly dental treatments. It is imperative that you stay on schedule for this routine, preventative care.

When we schedule appointments for patients in this office, we are very careful to allow a generous amount of time for each of our patients with both the doctor and the hygienist. The time allowed is very important for you to receive the individualized care that you deserve. The appointment time is reserved for patients who are committed to completing their necessary dentistry. To be fair to all our patients, **we require a notice of two business days** if you need to change (reschedule) your

appointment for an urgent reason. Because we preschedule our patients six months in advance, it is difficult to get you back into the schedule in a short period of time. ***Therefore, we ask that when you commit to a time, you make it a priority in your schedule.***

As a courtesy, we offer reminder calls, emails, and text messages in advance of your appointment. All these options are available to you. Let us know if you prefer one over another and we will do our best to accommodate you. **When you receive these reminders, it is important for you to follow the directions provided and confirm your appointment**. Please understand that an appointment is ultimately a reservation with the doctor and/or hygienist. We ask that you do all you can to arrange your schedule in a way that will enable you to be here for your appointed time. **A No Show/Late Cancellation is defined as a failed appointment.**

We do understand that sometimes things come up that are beyond your control and you may not be able to be here for your reserved time. Consideration will be given for extenuating circumstances that do not allow you to give the required two business day notice. **We reserve the right to "charge or waive" a fee ($50.00) for the first failed/cancelled appointment without the required notification. Any subsequent failed or missed appointments without the two-business day notification will incur a charge (equal to the cost of services that were to be provided), additionally a credit card may be required to schedule all future appointments.**

Please acknowledge below that you understand our Financial Policy Acknowledgement, Reserved Appointment Policy, and Notice of Privacy Practices.

☐ I acknowledge that I understand the Financial Policy Acknowledgement, Reserved Appointment Policy, and Notice of Privacy Practices. *

Your Name *
