

Patient Registration

First Name: _____ Home Phone: _____ Cell#: _____

Last Name: _____ Work Phone: _____ Email: _____

Address: _____ Social Security #: _____

City, State, Zip: _____ Date of Birth: _____

S M D W : Medical Alert: _____

Family Physician: _____ Phone: _____

Who may we thank for referring you? _____

Person responsible for account if other than patient: _____

Address: _____ Home Phone: _____

City, State, Zip: _____

Employer: _____ Work Phone: _____

Address: _____

Primary Insurance Information: Insured: _____

Insured's Employer: _____

Insurance Company Name: _____

Address: _____ Phone: _____

City, State, Zip: _____

Group or Policy Number: _____

Insured's SS#: _____ Date of Birth: _____

Secondary Information Insured: _____

Insurance Company Name: _____

Address: _____ Phone: _____

City, State, Zip: _____

Group or Policy Number: _____

Insured's SS#: _____ Date of Birth: _____

PATIENT MEDICAL HISTORY

Are you under medical treatment now? YES _____ NO _____ For: _____

Have you ever been hospitalized for any surgical operation or serious illness? YES _____ NO _____ For: _____

Are you taking medication(s) including non-prescription medicine: YES _____ NO _____

If yes, what medication(s) are you taking, AND for what reason? _____

Are you taking any over the counter or Prescription medicine for Weight Loss? YES _____ NO _____

Do you use tobacco? YES _____ NO _____ How Often _____

Are you wearing contact lenses? YES _____ NO _____

Are you allergic to or have you had any reactions to the following?

Local Anesthetic _____ Penicillin _____ Aspirin _____ Iodine _____
 Sulfa _____ Barbiturates _____ Sedatives _____ Others _____

Do you prefer to have dental anesthetic (lidocaine) with your dental procedures? _____

Women Only YES NO

Are you pregnant or think you may be _____

Are you nursing? _____

Are you taking birth control pills? _____

Have you ever had any of the following: (Please check)

Year you last had a physical with an M.D. _____ Chest X-ray? _____ Bloodwork? _____

High Blood Pressure _____ Respiratory Problems _____ Heart Surgery/Disease _____

Low Blood Pressure _____ Rheumatic Fever _____ Angina _____

Swollen Ankles _____ Asthma _____ Mitrovalve Prolapse _____

Hepatitis/Jaundice _____ Emphysema _____ Heart Murmur _____

Stroke _____ Organ Transplant _____ Epilepsy/Convulsions _____

Stomach Ulcers _____ Joint Replacement _____ AID or HIV or STD _____

Hay Fever/Allergies _____ Cardiac Pacemaker _____ Tuberculosis _____

Cancer _____ Radiation Therapy _____ Thyroid Problems _____

Leukemia _____ Hepatitis _____ Recent Weight Loss/gain _____

Glaucoma _____ Liver Disease _____ Arthritis _____

Have you had any prosthetic placed anywhere in your body? (as in pins, rods, etc.) _____

Any other conditions not mentioned above: _____

PATIENT DENTAL HISTORY

	YES	NO	Do you...
Do your gums bleed while brushing or flossing?	_____	_____	...snore yes no
Are your teeth sensitive to hot or cold?	_____	_____	...ear aches yes no
Are your teeth sensitive to sweet or sour?	_____	_____	
Do you feel pain in any of your teeth?	_____	_____	
Do you have any sores/lumps in or near your mouth?	_____	_____	
Have you had any head, neck, or jaw injuries?	_____	_____	
Have you ever experienced any of the following problems in your jaw:			I'd like to know more about....
A) Clicking	_____	_____	Improving my smile _____
B) Pain (joint, ear, side of face)?	_____	_____	veneers _____
C) Difficulty in opening or closing?	_____	_____	Ceramic crowns _____
D) Difficulty in chewing or swallowing?	_____	_____	Invisalign _____
Do you have frequent headaches?	_____	_____	Orthodontics _____
Do you clench or grind your teeth?	_____	_____	
Do you bite your lips or cheeks frequently?	_____	_____	
Have you ever had any difficult extractions?	_____	_____	
Or...prolonged bleeding following an extraction?	_____	_____	
Have you ever had any orthodontic (braces) work?	_____	_____	If you could straighten your teeth
Have you ever had any periodontal gum) treatment?	_____	_____	Invisibly would be interested? _____
Have you received instruction on proper brushing?	_____	_____	
Or...on the care of your gums?	_____	_____	

I certify that I have read and answered the preceding questions to the best of my knowledge. I also know that both doctor and staff are available to answer any questions that I may have. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist allowing me to pay only the deductible and copay at the time of service. I understand that my dental insurance carrier may pay less than the estimated benefits; therefore, I agree to be responsible for the payment of all services rendered on my behalf or my dependents'.

Patients Signature: _____ Date: _____ Dr. Signature: _____

FINANCIAL POLICY

Dear Patient:

It is the intention of all our personnel to provide you with quality dental care as thoroughly and efficiently as possible. In addition, we will endeavor to make your visit with us a pleasant and comfortable one!

The following is our office policy regarding payment for dental services rendered:

A. Payment in full at each visit is the office policy. Your insurance will be processed for you but your entire portion is expected at the time services are rendered.

B. Payment in full within 28 days of first billing. (No finance charge) A 10% annual finance charge will be added to any monthly balance not paid within billing cycle. No balances are to remain on account beyond the third billing cycle, which is 90 days. Any balance in the 90 days past due will have a carrying charge added to the total each month.

C. Insurance - In order to fully cooperate with families who are assisted by dental insurance, we ask that you be prepared to supply the following: an insurance form with name and address of your insurance company and policy numbers when you arrive for treatment. Also, expect to pay your deductible and any portion not covered by insurance at the time of service. Typically, there is an annual \$50.00 deductible. We will promptly fill out insurance claims to assist you in receiving the maximum benefit from your insurance company.

All policies have limitations and some may not cover 100% of the fee for services. Please remember that although we will assist you with your claim, you are personally responsible for payment of fees. In the event your insurance company does not pay within 60 days of filing your claim, you will be required to make other arrangements with us. We will preauthorize treatment so you can better understand your benefits of various procedures. A preauthorization is an estimation of coverage, based on insurance usage received. In the event that your insurance does not make payment within 45 days, you then become responsible for the remaining balance. It is your responsibility. To supply us with the proper insurance company and supply the insurance company with any additional information they may request regarding work or school.

We do cooperate with various insurance payment schedules but not all. Additionally, know that we do not adjust any tooth colored restorations for any insurance plan. This is the only exception. We routinely place tooth colored restorations but you may choose amalgam. If amalgam (silver) is your preference then it is your responsibility to inform us prior to treatment.

In case of default of payment for any services completed, I agree to pay reasonable and just attorney and collection fees incurred by Mary Ellen Hoyer D.D.S. and Associates in enforcing the collection of my account if the payment is not forthcoming within a reasonable amount of time. I understand and agree to the above financial agreements.

We may contact you via e-mail, if you have provided us with your address.

SIGNATURE

DATE

FYI: our appointment policy is as follows: If you need to change your appointment, at least 24 hrs. notice is required so that we may accommodate others. Otherwise, repeated failure to do so will result in a \$25.00 charge per half hour missed. We understand emergencies arise, but remember for every appointment you make and fail to keep, another patient has been forced to wait for their dental care.

ACKNOWLEDGEMENT OF RECEIPT FOR NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my 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 provider who may be involved in that treatment directly and indirectly.
- 2.) Obtain payment from third-party payers.
- 3.) Conduct normal healthcare operation such as quality assessments and physician certifications.

I have received and read and understand 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 the *Notice of Privacy Practices* from time to time and that I may contact this organization to 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 operation. I also understand you are not required to agree to my requested restriction, but if you do agree then you are bound to abide by such restrictions.

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____ Date: _____

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Name of Patient: _____ Date of Birth: _____

I request that all communication including account statement billing to me by Dr. Hoye and/or her associates and staff to be handled in the following manner:

*Written communications: Address to :

*Written communications: E-Mail Address to:

*Oral communication: Home # _____

May we leave a message? Yes ___ No ___

Work # _____

May we leave a message? Yes ___ No ___

Cell # _____

May we leave a message? Yes ___ No ___

May we Text Message you? Yes ___ No ___

May we leave message regarding any and all prescriptions and/or pre-meds? Yes ___ No ___

May we leave message regarding any and all appointment scheduled or needed? Yes ___ No ___

FOR OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices, but was unable to do so as documented

Date: _____ Initials: _____ Reasons: _____

