Patient Registration Form

Personal Information

Patient _____
First Name Initial Last Name

Address _____
City _____ State _____ Zip _____
Home Phone _____ Work _____ Cell _____
Email Address _____Birthday_____
Sex: M F Marital Status: S M W Sep D Social Security _____
Full time student Yes_____NO_____Where_____
Can we use your e-mail for electronic correspondence?
E-mail: Yes_____ No_____

Responsible Party _____
First Name Initial Last Name

Emergency Contact
Name _____ Relation _____
Phone number _____Alternate Phone number _____

Insurance Information (If you do not know the following information please contact your insurance company by phone or internet.)

Subscribers Name _____ Social Security _____ DOB _____
Insurance Company _____ Group Number _____

Secondary Insurance Information
Subscribers Name _____Social Security _____DOB_____
Insurance Company _____Group Number _____

Referral source
How did you hear about us?_____

Dental Information
Former Dentist:_____ Date of Last Dental X-Rays:_____

Authorization
I certify that I, and/or my dependent(s), have insurance coverage with _____and assign directly to Dr. Bailey all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

_____ _____
Signature of patient, parent, guardian, or personal representative **Date**

_____
Please print name and Relationship to patient

Dental/Medical History

Are you having pain or discomfort at this time?	Y	N
Do you feel very nervous about having dental treatment?	Y	N
Have you ever had a bad experience in a dental office?	Y	N
Have you been a patient in the hospital during the past two years?	Y	N
Have you been under the care of a medical doctor during the past two years?	Y	N
Have you had any excessive bleeding requiring special treatment?	Y	N
What is your Blood Pressure? LOW? NORMAL? HIGH? Last taken?		
Do you take or have you taken Bisphosphonates? (Didronel, Skelid, Fosamax, Actonel, Boniva, Aredia, Zometa)	Y	N
Have you had any Radiation Therapy for Pituitary or Thyroid disease?	Y	N
When was your last dental cleaning and exam?		

Women:

Are you pregnant now?	Y	N
Are you taking birth control pills?	Y	N
Do you anticipate becoming pregnant	Y	N

Medications	**Allergies**
List any medications you are currently taking and the corresponding diagnosis:	List any Allergies to medications you have:
	List any Surgeries you have had:
Pharmacy Name:	
Pharmacy Phone:	

Circle any of the following, which you have had or have at present:

Heart Failure	Anemia	Diabetes	Hepatitis C
Heart Disease or Attack	Stroke	Cortisone Medicine	Blood Transfusion
Angina Pectoris	Kidney Trouble	Glaucoma	Drug Addiction
High Blood Pressure	Ulcers	Chemotherapy	Hemophilia
Low Blood Pressure	Bruise Easily	AIDS Related complex (ARC)	Cold Sores
Heart Murmur	Pain in Jaw Joints	AIDS/HIV	Epilepsy or Seizures
Congenital Heart Lesions	Tuberculosis (TB)	Hepatitis A (infectious)	Fainting or Dizzy Spells
Heart Pacemaker	Sinus Trouble	Hepatitis B (sarum)	Nervousness
Heart Surgery	Congenital Defects/Valve	Sickle Cell Disease	Psychiatric Treatment
Artificial Joints	Mitral Valve Prolapse		

Do you have any missing teeth you would like to replace?	Y	N	
Are you unhappy with the appearance of your teeth?	Y	N	
How often do you floss?	1/day	2/day	none
How often do you brush?	1/day	2/day	none
Have you lost or gained more than 10 pounds in the past year?	Y	N	
Are you on a special diet?	Y	N	
Has your medical doctor ever said you have cancer or a tumor?	Y	N	
Do you have any disease, conditions, or problems not listed? If yes, please list:	Y	N	
Have you ever had tonsillectomy (tonsils taken out?)	Y	N	

Please circle if you have had problems with any of the following:

Bad Breath	Grinding Teeth	Bleeding Gums
Clicking or popping jaw	Loose teeth or broken fillings	Periodontal Treatment
Food collection between teeth	Sensitivity to cold/hot/sweets	Sores or growths in the mouth

Please circle any of the following childhood diseases you have had?

Measles	Chicken Pox	Mumps	Whooping Cough
Scarlet Fever	Scarletina	Diphtheria	Tonsilitis

Do you use any of the following products? (Please circle)

Cigarettes Alcohol Cigars Chewing tobacco Pipe Snuff

Michael L. Bailey, D.D.S.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

I, _____, have read and understand this office's Notice of Privacy Practices. (This information is laminated on the clipboard for your perusal, or you may ask for a copy.)

_____
{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)

_____

_____

_____

Superior Dental
Financial Policies

In order to enhance communication and promote understanding regarding this office's Financial Policies, please read through the following information. After reading, please provide your signature at the bottom indicating that you fully understand these policies. This form must be signed in order to proceed with your scheduled appointment. Please feel free to ask us about any questions or concerns you may have. Thank you!

- Insurance**:** At Superior Dental, we are happy to bill both primary and secondary insurances for you. We feel it is important to explain, however, that **insurance companies cannot guarantee dental benefits to us, and all estimates for your portion due are truly only an estimate.** It must be understood that each patient is ultimately responsible for the cost of services rendered. We will do our best to estimate accurate insurance coverage and patient portions due; however, if the insurance company does not pay the full amount anticipated, the patient is responsible for the difference. Payment would be expected within 30 days of receiving a statement. Insurance is never a guarantee of coverage. I understand that **posterior restorations are often paid with an "alternate benefit"**, and I will be responsible for the difference.

- Patient Payment: The **patient portion due for services rendered is expected at the time of service** unless *previous* arrangements have been made with the office. We accept cash, checks, and all major credit cards. If Payment is not made as agreed, I understand that I am responsible for any and all interest, late fees, attorney fees, collections costs, and court costs incurred in an effort to enforce this agreement.

- Financing**:** We have financing available through Care Credit. If you have an interest in this option, please consult with the office prior to the date of scheduled treatment.

- No Shows/Missed Appointments**:** We request notice to cancel or **reschedule an appointment at least 48 hours in advance**. If appropriate notice is not given, a charge of **$75 may be assessed** to the patient's account. After 3 missed appointments, Dr. Bailey will not reserve appointments for you.

- Refunds for Unfinished Treatment**:** If a patient decides to discontinue treatment after it has been started, a full refund will not be given. Individual circumstances may be discussed with the office.

- Credits on an Account**:** If an insurance company pays more than anticipated creating a credit for the patient, we are happy to either refund the patient or leave the credit on the account to be applied toward future treatment.

- Collections**:** On occasion, after repeated attempts to collect a balance due, we may need to turn an account over to a collections attorney. Should this occur, it is agreed that the financially responsible party listed below shall pay all finance charges, collection cost, attorney's fees, and any other costs that may be incurred to enforce collection of any amount outstanding. I agree that any dispute about the reasonableness or computation of fees, or any claim of negligent or intentional acts or omissions in the rendering of professional services by any member of Dr. Michael Bailey's staff or our doctors, shall be submitted to binding arbitration. It is understood by both doctor and patient that by agreeing to submit all claims or assertions that either patient or doctor may have against the other, arising out of this agreement, all disputes shall be resolved through arbitration.

I, _____, in consideration of services rendered and pursuant to this agreement, do personally guarantee the full payment of all sums of money due to Dr. Michael Bailey.

Patient Name:_____ Date:_____

Financially Responsible Person:_____

Signature of Financially Responsible Person: _____