PATIENT REGISTRATION

DATE___________________

NAME____

PREFERRED NAME____

ADDRESS____

CITY____________________STATE______ZIP CODE________________

HOME NUMBER______________________________________

MOBILE NUMBER_____________________________________

EMAIL ADDRESS____

BIRTHDATE___________ PREFERRED PRONOUNS___________________

SOCIAL SECURITY NUMBER_____________________________________

MARRIED _____ SINGLE _____ DIVORCED_____ WIDOWED_____

OCCUPATION____

WHO REFERRED YOU?____

FINANCIALLY RESPONSIBLE PARTY

NAME_______________________________________

RELATIONSHIP TO PATIENT____________________________________

CONTACT NUMBER________________________

EMERGENCY CONTACT

NAME _______________________________________

RELATIONSHIP _______________________________

PHONE NO.___________________________________

DENTAL INSURANCE- PRIMARY POLICY

INSURANCE COMPANY_________________________________

GROUP #___________________________________

EMPLOYER_________________________________

INSURED'S NAME_______________________________________

INSURED'S BIRTH DATE____________________

I.D. #_______________________________________

INSURED'S SOCIAL SECURITY NO.______________________________________

RELATIONSHIP TO PATIENT_________________

DENTAL INSURANCE- SECONDARY POLICY

INSURANCE COMPANY_________________________________

GROUP #___________________________________

EMPLOYER_________________________________

INSURED'S NAME_______________________________________

INSURED'S BIRTH DATE____________________

I.D. #_______________________________________

INSURED'S SOCIAL SECURITY NO.______________________________________

RELATIONSHIP TO PATIENT_________________

Patient Name	**DENTAL HISTORY**
Patient Account No.	Medical Alert

Welcome! So that we may provide you with the best possible care please complete both sides of this medical/dental history form. All information is completely confidential.

What is the reason for your visit today? ______________________

Date of Last Dental Visit __________ **Last Dental Cleaning** __________ **Last Full Mouth X-rays** __________

What was done at your last dental visit? ______________________

Previous Dentist's Name ______________________

Address ______________________ State ______ Zip ______

Telephone ______________________

How often do you have dental examinations? ______________________

How often do you brush your teeth? __________ How often do you floss? __________

What other dental aids do you use? (Interplak, toothpick, etc.) ______________________

Do you have any dental problems now? Yes No

If yes, please describe: ______________________

Are any of your teeth sensitive to:		
Hot or cold?	Yes	No
Sweets?	Yes	No
Biting or Chewing?	Yes	No
Have you noticed any mouth odors or bad tastes?	Yes	No
Do you frequently get cold sores, blisters or any other oral lesions?	Yes	No
Do your gums bleed or hurt?	Yes	No
Have your parents experienced gum disease or tooth loss?	Yes	No
Have you noticed any loose teeth or change in your bite?	Yes	No
Does food tend to become caught in between your teeth?	Yes	No

If yes, where? __________

Do you:		
Clench or grind your teeth while awake or asleep?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails)	Yes	No
Mouth breathe while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Smoke/chew tobacco?	Yes	No

Have you ever had:		
Orthodontic treatment?	Yes	No
Oral surgery?	Yes	No
Periodontal treatment?	Yes	No
Your teeth ground or the bite adjusted?	Yes	No
A bite plate or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No

If so, please describe, including cause __________

Have you experienced:		
Clicking or popping of the jaw?	Yes	No
Pain? (joint, ear, side of face)	Yes	No
Difficulty in opening or closing the mouth?	Yes	No
Difficulty in chewing on either side of the mouth?	Yes	No
Headaches, neckaches or shoulder aches?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No
Are you satisfied with your teeth's appearance?	Yes	No
Would you like to keep all of your teeth all of your life?	Yes	No
Do you feel nervous about having dental treatment?	Yes	No

If so, what is your biggest concern? __________

Have you ever had an upsetting dental experience?	Yes	No

If yes, please describe __________

Is there anything else about having dental treatment that you would like us to know? Yes No

If yes, please describe ______________________

(Please complete other side)

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Patient Name

Patient Account No.

Medical Alert

MEDICAL HISTORY

1. Have you been under the care of a medical doctor during the past two years? Yes No
   If yes, for what? ____
   Physician's Name ____ Phone ____
   Address ____ City ____ State ____ Zip ____
2. Have you taken any medication or drugs during the past two years? Yes No
3. Are you taking any medication, drugs or pills now, including regular dosages of aspirin? Yes No
   If yes, please list name and dosage ____
4. Have you ever taken prescription medications for weight loss (diet pills)? Yes No
   If yes, did you take any of the following:
   Yes No Fen-Phen (Fenfluramine-Phentermine)
   Yes No Pondimen (Fenfluramine)
   Yes No Redux (Dexfenfluramine)
   If yes to any of the above, did you have a medical exam for heart issues? Yes No
5. Are you aware of having an allergic **(or adverse)** reaction to any medication or substance? Yes No
   If yes, please list: ____
6. Have you been a patient in the hospital during the past five years? Yes No
7. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

						Smoke/ chew tobacco	Yes	No
Heart (Surgery, Disease, Attack)	Yes	No	Ulcers	Yes	No	Hepatitis A (infectious) B (serum)	Yes	No
Chest Pain	Yes	No	Diabetes	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disease	Yes	No	Thyroid Problems	Yes	No	A.I.D.S.	Yes	No
Heart Murmur	Yes	No	Glaucoma	Yes	No	H.I.V. Positive	Yes	No
High Blood Pressure	Yes	No	Contact lenses	Yes	No	Cold Sores/Fever Blisters	Yes	No
Mitral Valve Prolapse	Yes	No	Emphysema	Yes	No	Blood Transfusion	Yes	No
Artificial Heart Valve	Yes	No	Chronic Cough	Yes	No	Hemophilia	Yes	No
Heart Pacemaker	Yes	No	Tuberculosis	Yes	No	Sickle Cell Disease	Yes	No
Rheumatic Fever	Yes	No	Asthma	Yes	No	Bruise Easily	Yes	No
Arthritis/Rheumatism	Yes	No	Hay Fever	Yes	No	Liver Disease	Yes	No
Cortisone Medicine	Yes	No	Latex Sensitivity	Yes	No	Yellow Jaundice	Yes	No
Swollen Ankles	Yes	No	Allergies or Hives	Yes	No	Neurological Disorders	Yes	No
Stroke	Yes	No	Sinus Trouble	Yes	No	Epilepsy or Seizures	Yes	No
Diet (Special/Restricted)	Yes	No	Radiation Therapy	Yes	No	Fainting or Dizzy Spells	Yes	No
Artificial Joints (hip, knee, etc.)	Yes	No	Chemotherapy	Yes	No	Nervous/Anxious	Yes	No
Kidney Trouble	Yes	No	Tumors	Yes	No	Psychiatric/Psychological Care	Yes	No

8. Do you use more than two pillows to sleep? Yes No
9. Have you lost or gained more than 10 pounds in the past year? Yes No
10. Do you have or have you had any disease, condition, or problem not listed? Yes No
    If yes, please list: ____
11. **Women.** Are you: **Pregnant**? Yes, ___Months No **Nursing**? Yes No **Taking birth control pills**? Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health or medication.

Patient/Guardian Signature ____ Date ____

History Review

EMERGENCY CONTACT:

Dentist Signature ____ Date ____

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FINANCIAL POLICY

- Payment is due at the time services are rendered. We accept cash, checks, **Visa, MasterCard, Discover** and **American Express.**
- If you have insurance, we will gladly bill your insurance company. Our office is not responsible for the terms, and conditions, set by your insurance company. This includes insurance dollars, as well as any treatment limitations. As the policy holder, it is imperative that you track how your benefits are utilized throughout the year. Any ***estimated*** co-pay, or deductible, is to be paid at the time of service.
- Dr. Chase is a preferred provider with Cigna, Delta Dental, and Premera Blue Cross. If you are insured with another insurance company, please contact that company to determine if you are free to choose your own dentist.
- Billing statements are normally issued on, or after, the 15th of each month. ***Payment is due within 10 business days of receipt of the statement.*** Any account with a balance that exceeds 90 days is subject to collections, a 1.5% finance charge, and risk of being dismissed from the practice.
- Our office does not provide financing. Payment options are offered through Care Credit.
- Cancelling, rescheduling, or failing to show for an appointment without two business days notice, will result in a $100 fee.

By signing below, you agree to all the terms and conditions contained herein, and the agreement will be in full force and effect.

Patient's Name:

____

Responsible Party (if patient is under 18 years of age):

____

Signature: ______________________ Date: ______________________

Assignment of Benefits

I give consent to Dr. Laura Chase to share any electronic, written, or oral medical or dental records with my insurance company in the claims process. I understand that only the minimum amount of necessary information is shared to provide necessary quality dental care, and to collect the maximum benefits under my plan.

I consent to have all insurance payments made directly to Dr. Chase by my insurance company. I understand that I am responsible for full payment of any unpaid balance by my insurance, as well as any expense incurred by Dr. Laura Chase in the collection of this balance. I have agreed to pay my co-insurance in my documentation upon enrollment.

Signed:____________________________________ Date:________________

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Authorization and Consent

To Send Unencrypted Patient Information by Email and Other Electronic Means

Until I tell you in writing to stop, I authorize Laura L. Chase, DDS, PS to transmit patient information relating to my treatment, health, or payment by email or other electronic means, without encryption or special security precautions, to me or someone I designate, or to other health care providers, health plans and others involved in my treatment, payment for my treatment, or Laura L. Chase, DDS, PS health care operations. The patient information that may be emailed may include my x-rays, health history, diagnosis, treatment, and payment records.

I understand that:

- I do not have to sign this form.
- My treatment, payment, enrollment and eligibility for benefits will not be affected by my decision about signing this form.
- If I don't sign this form, Laura L. Chase, DDS, PS may use other ways to send my information, such as U.S. Mail, or may ask me to send my information to third parties myself.
- There is some risk that emails and other electronic messages may be improperly acquired by hackers or received by unintended recipients. If that happens, the information may be redisclosed and no longer protected by privacy law.
- **Laura L. Chase, DDS, PS *does not* email such sensitive personal information as Social Security numbers, credit card numbers, mental health diagnosis, genetic information, alcohol/substance abuse, or positive HIV status unless the patient insists.**

I can tell you in writing to stop emailing my patient information at any time, but if I do so, this will not affect emails that Laura L. Chase, DDS, PS already sent before receiving my written instructions to stop.

Patient name (please print) ______________________

Signature: ___________________________________ Date: _______________

CONSENT FOR TREATMENT

1. I hereby authorize doctor, or designated staff, to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) ___________________________'s dental needs.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me, and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. I give consent to the doctor's, or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used, or disclosed, and that a notice fully outlining the protection of my personal health information is available.

5. I agree to be responsible for payment of all services rendered on my behalf, or my dependents, regardless of insurance coverage. I understand that payment is due at the time of service, and that financing is only available through Care Credit, and not provided by the doctor's office. In the event payment is not made at the time of service, I understand that a 1.5% late fee will be applied to my account every month until the balance is paid. I also understand that if my account is not paid within 90 days from the date of service, my account will be referred to collections, and I will be dismissed from the practice.

Patient's Signature ____ Date __________________________

Parent/Responsible Party's Signature ____________________________ Relationship to Patient __________