# PATIENT REGISTRATION

**First Name:** ______________________ **Last Name:** ________________________ **Middle:** ______

**Preferred Name:** ______________________

**Patient is:** □ Responsible Party □ Policy Holder

**Responsible Party: ( if someone other than the patient )**

First Name: ______________________ Last Name: ________________________ Middle Initial: ____

Address: ____________________________________________________________

City, State, Zip: ____________________________________________________________

Home Phone: ____________________ Work Phone: ________________ Cell Phone: ______________

Birth date: ______________ Social Security #: __________________ Drivers Lic#: ______________

○ Responsible Party is Policy Holder for Patient ○ Primary Policy Holder ○ Secondary Policy Holder

**Patient Information:**

Address: ____________________________________________________________

City, State, Zip: ____________________________________________________________

Home Phone: ____________________ Work Phone: ________________ Cell Phone: ______________

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

Birth date: ______________ Social Security #: __________________ Drivers Lic#: ______________

E-mail: □ I would like to receive email correspondences

**Patient Information (section 2):**

Preferred Pharmacy: ____________________________ Referred By: __________________________

Previous Dentist: ______________________________

Emergency Contact: ___________________________ Phone #: _____________________________

**Primary Insurance Information:**

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

Employer ID: ________________________ Carrier ID: ______________________________

Insured Social Security #: ________________ Insured Birth date: ________________________

Employer: ___________________________ Insurance Company: _______________________

**Secondary Insurance Information:**

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

Employer ID: ________________________ Carrier ID: ______________________________

Insured Social Security #: ________________ Insured Birth date: ________________________

Employer: ___________________________ Insurance Company: _______________________

Time 3:57 PM | Dr. Ragan Faler, DMD, PC | Date 10/28/2024

**Eaglesoft Medical History**

Patient Name: Birth Date: Date Created:

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, c

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

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

| | | | |
|---|---|---|---|
| ☐ Aspirin | ☐ Penicillin | ☐ Codeine | ☐ Acrylic |
| ☐ Metal | ☐ Latex | ☐ Sulfa Drugs | ☐ Local Anesthetics |

Other? ☐ If yes

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

| Condition | | Condition | | Condition | | Condition | |
|---|---|---|---|---|---|---|---|
| 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 Problems | ◯ 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 If yes

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:

X______________________________ Date:__________

# Patient consent to receive mail and/or telephone messages

Please print (Last Name) (First Name) (M.I.)

Email Address (please print)

**Do we have your permission to?**

Send a recall appointment reminder to your house: Y______N_____

Leave appointment, billing or dental information on

Your answering machine/voice mail/e-mail: Y______N______

I give permission to share appointment, billing information and medical information with the person/s named below:

Name relationship phone number

Name relationship phone number

Name relationship phone number

Please provide us with the best phone number (s) to reach you at in the event of bad weather.

Phone number(s)

**Acknowledgment of Receipt of Notice of Privacy Practices**

I have received copy of the notice of Privacy Practices with an effective date of April 14, 2003

Signature of Patient /Parent or Legal Guardian Date

## Appointments and Cancellations

When we make your appointment, we are reserving a room for your particular needs. We ask that if you must change or cancel an appointment, please give us at least **24-hour's notice** *(for any routine appointment)* **and/or 1 week notice** *(for any surgery appointment greater than **ONE** hour long)*. This courtesy makes it possible to give your reserved room to another patient who would like it.

If you cancel or fail to show for your confirmed SURGERY appointment, or if you arrive excessively late and treatment cannot be completed as planned, Dr. Faler reserves the right to recover lost opportunity and associated costs with a **BROKEN APPOINTMENT FEE OF $100 per ½ hour**** ; *(fee associated with ANY surgery appointment greater than 1 hour in length)*

One week prior to your appointment you will receive a phone call and/or an email requesting a verbal confirmation for your upcoming appointment. When you receive this message, please **CALL** us back to confirm the time that you have already reserved with us. **If we do not get a VERBAL confirmation from you 4-BUSINESS DAYS prior to your reserved time, we will take your appointment off of our schedule.**

*Repeated cancellations or missed appointments will result in loss of future appointment privileges.*

We feel that our patient's time is valuable. When your appointment is made, a room is reserved, your records are prepared, and special instruments are readied for your visit. Except for emergency treatment for another patient, you can expect us to be prompt; we, of course, would appreciate the same courtesy from you.

## Late Arrival

If you are over **15 minutes** late for your appointment, we reserve the right to reschedule your appointment for a later time. Please understand that we strive to stay on time for your appointment as well as the patients that follow you. By signing below, you have read, and understand this agreement.

***We understand emergencies may arise and we will make allowances depending on the circumstances.*

-------------------------------------------------------------------- -------------------------

**Signature of Patient or Parent** **Date**

## Financial Agreement

At our dental practice, we are committed to providing high-quality care with transparency regarding our practice financial policy. We want to ensure you know what to expect regarding payments, insurance handling, and financial responsibility. Please review the information below to ensure a clear understanding of our financial policies.

### Financial Policy

Payment is due in full for services rendered at the time of service, unless prior arrangements have been made.

### Insurance Filing

As a courtesy to our patients, we will file dental insurance claims for services rendered. However, you the patient are ultimately responsible for any incurred balance for services rendered. We expect payment of deductibles, co-payments and balances to be made at the time services are rendered.

There are many dental insurance policies, and we do our best to provide an accurate **estimate** based on information provided by you and your insurance company. We strive to gather as much information as possible to provide an accurate estimate, however, insurance companies may adjust payments, and coverage/benefits are only determined at the time when a claim is submitted after services are rendered. **The estimates provided by us and your insurance company are not a guarantee of coverage/benefits.** Any unpaid balance is your responsibility and is due immediately. In an effort to avoid confusion, we recommend the following:

- **Familiarize yourself with your policy:**
  - Does your policy have a yearly deductible and what is the amount?
  - Know your policies' yearly maximums and when your benefit year starts.
  - Does your policy have a waiting period or missing tooth clause?
  - Know what your policy covers and what percentage of a procedure is covered.
  - Know the frequency and timing of your preventative maintenance program (some policies cover two cleanings per calendar year and others only cover every six months)
- **Bring correct insurance information to your appointment**:
  - Please provide us with your dental insurance ID card prior to the start of your appointment. We must have policy, group and ID numbers, and subscriber information to process your claim. We must also have the correct claims mailing address for your dental insurance carrier.

Dental insurance is meant to be an "aid" in receiving dental care. Our practice bases treatment on your needs, not what your insurance will pay. Some insurance companies may pay less, some pay more. Whether your insurance pays 100%, 80%, or 50% of a procedure, in most cases they are determining payment based on **their fee schedule** and set plan provisions within your policy, **not the actual fee** our office charges for the service.

By signing this agreement, you the patient hereby assign, directly to our office, insurance benefits otherwise payable to our office. You, the patient, hereby authorizes the release of any information relating to any claims. You the patient understand that you are financially responsible for charges not paid by this assignment.

### Past Due Accounts

You will receive statements from us directly for any outstanding balances. Statements will be delivered electronically. In the event we are unable to deliver a statement electronically, we will deliver the statement via paper mail. We recommend checking your spam/junk mailboxes regularly.

Past due balances 30 days and over may be subject to late fees, interest fees, and/or legal fees.

Delinquent accounts beyond 90 days from the date the balance was incurred will be turned over to a collection agency for non-payment. You, the patient, will be responsible for payment of any and all reasonable collection fees and/or attorney fees, in addition to the balance owed. Any account turned over to a collection agency forfeits any past special fees and/or discounts. Such special fees and/or discounts will be reversed and you will be responsible for payment of in full for services rendered at the time of service.

**Cancellation of Appointments**

If in the event you cancel without sufficient notice, or no show to a scheduled appointment, you will be assessed a reasonable cancellation/no show fee. Short notice cancellations and/or no shows are a significant contributor to rising health care costs. We ask that you provide us with sufficient notice should any changes need to be made to your scheduled appointment.

I have read the above information and agree to its terms:

________________________________________ ________________

**Signature** **Date**

# Consent for Services

In consideration for the professional services rendered to me, or at my request by the Doctor, I agree to pay the reasonable value of said services to the Doctor. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form or my treatment.

All emergency dental services, or any dental services performed without insurance confirmation of eligibility must be paid for in cash, check or card at the time services are performed.

You will be responsible for payment of your estimated amount, including deductibles and co-pays of your primary dental insurance.

I understand that when a treatment plan is given to me, that those fees will be honored for a 6 month period only. I understand that there may be an increase in fees from the date of the treatment plan.

***I have read the above conditions of treatment and payment and agree to their content.***

________________________________________ ____________________

**Signature of patient, parent or guardian** **Date**