Creekside Dentistry

Patient Registration

ID: _____ Chart ID: _____

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City State Alabama Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State Alabama Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

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

Birth Date: Age: Soc. Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

----- Section 2 ----- Section 3 -----

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Carrier ID: Pref. Hyg.:

Employer ID: Pref. Pharmacy:

Who referred you?:

Last cleaning/x-ray?:

Are you pleased with:

Tooth Shade?

Smile?

Previous Treatment?

Primary Insurance Information

Name of Insured: Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Insurance Company:

Address: Address:

Address 2: Address 2:

City: State Alabama Zip: City: State Alabama Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Insurance Company:

Address: Address:

Address 2: Address 2:

City: State Alabama Zip: City: State Alabama Zip:

Rem. Benefits: Rem. Deduct:

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, 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	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	

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

Do you use controlled substances?	◯ Yes ◯ No	If yes
Other?	☐	If yes

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

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	◯ 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:_____

Creekside Dentistry, LLC
Owner: Dr. Stewart Helton and Dr. Beau Upshaw

Acknowledgement of Receipt of HIPAA Policies and Procedures

* You May Refuse to Sign This Acknowledgment*

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

I have received and reviewed a copy of our dental practice's privacy, security and breach notification policies and procedures.

I understand that I should ask our dental practice's Privacy Official if I have any questions about these policies and procedures. Initial:_____

Financial Policies and Permission to File Insurance

For your convenience, we accept VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS and PERSONAL CHECKS. Our extended payment plan is available through CARE CREDIT.

Agreement to pay: The undersigned accept the fees charged as a lawful debt and promises to pay said fees including the costs of collection, attorney fees and court costs if such are necessary.

In regards to separated or divorced parents/guardians, the parent who brings the child to the office is responsible for the account. The office will not bill the other parent/guardian. The office will file insurance for each of our patients but will need all insurance information on the subscriber. This is your responsibility to obtain.

I authorize release of information to all insurance companies and permit this copy of my signature to be kept on file for processing dental insurance claims for myself or my child(ren).

I agree to pay my deductible and any portion of the dental fee not covered by my dental insurance plan at the time of service and I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the above named dental entity. Initial:_____

Patient name (Print name of patient being seen) :_____
DOB:_____

I, _____, have received a copy of Creekside Dentistry, LLC's 'Notice of Privacy Practices' and 'Financial Policies', and understand this also covers my children under the age of 18.

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)

Financial Agreement

Our goal is to provide the highest quality of dental care possible and to have clear communication regarding all office policies.

ALL ACCOUNTS ARE DUE AND PAYABLE AT TIME OF SERVICE. If a procedure requires multiple appointments, payment is required in full at the first appointment.

> **Payment options:** Cash, Check, Credit Card (MasterCard, VISA, Discover, or American Express), and Care Credit (feel free to ask our staff about this program).

PATIENTS WITH INSURANCE: The PATIENT is responsible for the ESTIMATED non-covered portion, procedures, and/or deductibles at the time of the service, and the PATIENTS RESPOINSIBLE PARTY will also be responsible for any balance remaining after insurance pays. If the insurance company does not pay after 90 days, we will bill you directly for the full balance.

PARENTS OF PATIENTS: If you are not accompanying your child to an appointment you must make PRIOR arrangements for payment (cash, check, or credit card authorization). Parents or guardians of patients under the age of 18 are financially responsible for payment.

There is a $30.00 processing charge for non-sufficient funds or returned checks.

Accounts with an outstanding balance over 90 days will be turned over to collections.

**** PLEASE READ ** To ensure that we can continue to provide the exceptional quality to all of our patients we ask that all appointments be canceled at least 48 business hours in advance. Because instruments, time, and personnel are reserved exclusively for you or your family member, there is a $50 CHARGE for late cancelations. We appreciate your cooperation in making this possible.**

PRINT NAMES AND DOB FOR ALL PATIENTS ATTENDING CREEKSIDE DENTISTRY:

_____ DOB: _____

_____ DOB: _____

_____ DOB: _____

_____ DOB: _____

_____ DOB: _____

By signing this agreement I _____ (Please Print), agree to the financial terms stated above.

Signature _____ Date: _____

Submit