SISTERS DENTAL

Patient Registration

First Name:_____ Last Name:_____ MI:____

Preferred Name:_____

Patient Information

Address:_____

City:_____ State:_____ Zip:_____

Mailing address: _____

Home Phone:_____ Work:_____ Cell:_____

Sex: □ Male □ Female Marital Status: □ Married □ Single □ Divorced

Birth Date:_____ Age:_____ Social Sec:_____

Drivers License:_____ Email:_____

I would like to receive correspondences via e-mail: □ yes □ no

Employment status: □ Full time □ Part time □ Retired

Student Status: □ Full time □ Part time

Referred By: □ TV □ Radio □ Patient:_____

Previous Dentist:_____ Last time to a dentist:_____

Emergency Contact:_____ Emergency Contact Phone #_____

Responsible Party (if someone other than the patient)

First Name:_____ Last Name:_____ MI:____

Address:_____ City/State/Zip:_____

Home Phone:_____ Cell:_____ Work:_____

Birth date:_____ Soc Sec:_____ Drivers Lic:_____

Primary Insurance Information

Policy Holder:_____

Relationship to Patient: □ Self □ Spouse □ Child □ Other

Policy Holders Soc. Sec:_____ Date of Birth:_____

Policy Holders ID #_____ Patients ID#_____

Employer:_____ Ins. Company:_____

Secondary Insurance Information

Policy Holder:_____

Relationship to Patient: □ Self □ Spouse □ Child □ Other

Policy Holders Soc. Sec:_____ Date of Birth:_____

Policy Holders ID #_____ Patients ID#_____

Employer:_____ Ins. Company:_____

Medical History

Although your dentist will 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 medications that you may be taking, could impact your overall oral health and your dental care. Thank you for answering the following questions.

Are you under a physician's care now? □ Yes □ No

If yes, please explain:_____

Have you ever been hospitalized or had a major operation? □ Yes □ No

If yes, Please explain:_____

Have you ever had a serious head or neck injury? □ Yes □ No

If yes, Please explain:_____

Are you taking any medications, pills, or drugs? □ Yes □ No

If yes, Please explain:_____

_____

Do you take, or have you taken, Phen-Fen or Redux? □ Yes □ No

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? □Yes □ No

Are you on a special Diet? □ Yes □ No

Do you use tobacco? □ Yes □ No

Do you use any controlled Substances? □ Yes □ No

Pregnant/Trying to get pregnant? □ Yes □ No

Taking Oral Contraceptives? □ Yes □ No Nursing? □ Yes □ No

Are you allergic to any of the following?

□ Aspirin □ Penicillin □ Codeine □ Acrylic □ Metal □ Latex □ Local Anesthetics □ Other:_____

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

AIDS/HIV	□ Yes □ No	Emphysema	□ Yes □ No
Alzheimer's Disease	□ Yes □ No	Epilepsy/Seizures	□ Yes □ No
Anaphylaxis	□ Yes □ No	Excessive Bleeding	□ Yes □ No
Anemia	□ Yes □ No	Excessive Thirst	□ Yes □ No
Angina	□ Yes □ No	Fainting Spells/Dizziness	□ Yes □ No
Arthritis/Gout	□ Yes □ No	Frequent Cough	□ Yes □ No
Artificial Heart Valve	□ Yes □ No	Frequent Diarrhea	□ Yes □ No
Artificial Joint	□ Yes □ No	Frequent Headaches	□ Yes □ No
Asthma	□ Yes □ No	Genital Herpes	□ Yes □ No
Blood Disease	□ Yes □ No	Glaucoma	□ Yes □ No
Blood Transfusion	□ Yes □ No	Hay Fever	□ Yes □ No
Breathing Problem	□ Yes □ No	Heart Trouble/Disease	□ Yes □ No
Bruise Easily	□ Yes □ No	Hemophilia	□ Yes □ No
Cancer	□ Yes □ No	Hepatitis A	□ Yes □ No
Chemotherapy	□ Yes □ No	Hepatitis B or C	□ Yes □ No
Chest Pains	□ Yes □ No	Herpes	□ Yes □ No
Cold Sores/Fever Blisters	□ Yes □ No	High Blood Pressure	□ Yes □ No
Congenital Heart Disease	□ Yes □ No	Hives or Rash	□ Yes □ No
Convulsions	□ Yes □ No	Hypoglycemia	□ Yes □ No
Cortisone Medicine	□ Yes □ No	Irregular Heartbeat	□ Yes □ No
Diabetes	□ Yes □ No	Kidney Problems	□ Yes □ No
Drug Addiction	□ Yes □ No	Leukemia	□ Yes □ No

Low Blood Pressure	□ Yes □ No	Sickle Cell Disease	□ Yes □ No
Lung Disease	□ Yes □ No	Sinus Trouble	□ Yes □ No
Mitral Valve Prolapse	□ Yes □ No	Spina Bifida	□ Yes □ No
Osteoporosis	□ Yes □ No	Stomach/Intestinal Disease	□ Yes □ No
Pain in Jaw Joints	□ Yes □ No	Stroke	□ Yes □ No
Parathyroid Disease	□ Yes □ No	Swelling of Limbs	□ Yes □ No
Psychiatric Care	□ Yes □ No	Thyroid Disease	□ Yes □ No
Radiation Treatment	□ Yes □ No	Tonsillitis	□ Yes □ No
Recent Weight Loss	□ Yes □ No	Tuberculosis	□ Yes □ No
Renal Dialysis	□ Yes □ No	Tumors or Growths	□ Yes □ No
Rheumatic Fever	□ Yes □ No	Ulcers	□ Yes □ No
Rheumatism	□ Yes □ No	Venereal Disease	□ Yes □ No
Scarlet Fever	□ Yes □ No	Yellow Jaundice	□ Yes □ No
Shingles	□ Yes □ No		

Have you ever had any serious Illness not listed above? □ Yes □ No

If yes, please explain:_____

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 patients) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, or Responsible Party:_____ Date:_____

Sisters Dental Financial Agreement

We are committed to providing outstanding dental care for you and your family. Our fees are based on the quality materials we use and the time, effort, and skill required to deliver excellent dental care. Thank you for choosing our team at Sisters Dental to provide your dental health care.

We accept the following forms of payment: cash, check, and all major credit cards. Payment is due at the time of service. Checks that are returned to our office from your financial institution are subject to a $25.00 retuned check fee to cover the processing fees charged to our office.

Your appointment time has been reserved exclusively for you and our doctors and team invest significant time into preparing for your visit. Broken and missed appointments create scheduling problems for our team and for other patients. If you must change your scheduled appointment, we require a minimum of 24 hour notice so that we may make every effort to accommodate other patients. If proper notice is not received a fee of $50.00 will be charged to your account.

Due to the amount of time reserved and preparation required for more extensive services, a deposit of 10% of the total fee will be collected at time of scheduling for treatment plans exceeding $5,000.

Balances older than 60 days may be subject to additional collection fees and interest charges of 1.5% per month. These financing charges will be applied to the unpaid balance at the end of the month. In the event that an account goes unpaid we may refer the account to collections, you are then responsible for all fees incurred in the collection of your overdue account.

As a courtesy to our patients we follow a small balance write off policy; after any outstanding insurance claims are paid, any total balance of less than $5.00 will be written off of your account during monthly account reconciliation. In an effort to reduce costs associated with accounting and collections we will similarly write off any credit of less than $5.00.

For our patients with a dental insurance plan we are happy to assist you with your benefit eligibility to help you calculate your costs and maximize your insurance benefits. Your insurance policy is an agreement between you and the insurance company; we ask that all patients be directly responsible for all charges. Your estimated co-payment will be due at the time of service. We will submit claims to help you receive the full benefit of your coverage, however we cannot guarantee any estimated coverage. By signing this form you authorize Sisters Dental to disclose to your insurance company any information necessary for submitting insurance claims on your behalf.

For our patients not using dental insurance we offer a 5% discount when payment is made in full with cash or check at the time your services are initiated.

I have read and agree to the financial agreement with Sisters Dental. I understand I am responsible for charges for all services rendered. If applicable, I authorize Sisters Dental for submit any information necessary for processing insurance claims on my behalf.

Name of patient: _____

_____

Signature of patient or responsible party Date

Sisters Dental
Acknowledgement of Receipt of Privacy Practices

491 E Main Ave, Sisters OR 97759

The Notice of Privacy Practices describes how health information about you may be used and disclosed and how you can get access to this information. Please review the Notice carefully.

By signing below I acknowledge that:

- A copy of the Notice of Privacy Practices has been provided for me to read and a copy is available upon request at now or at any time in the future.
- I am either the patient or the patient's responsible party.

Signature of patient or responsible party Date