



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

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



Notice of Privacy Practices Acknowledgement

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.

If you have questions about the Notice of Privacy Practices, please feel free to contact our Privacy Office at any time. The name and contact for the Privacy Officer is listed on the Notice of Privacy Practices.

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.

Printed name

Date of Birth

Signature of patient or responsible party

Date