TIME 11:12 AM DATE 2/10/2016

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, 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 / 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

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

Pharmacy Name

Pharmacy Number

Email Address

Primary Insurance Information

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

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, 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: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

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

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

Other?	☐	If yes
Do you use controlled substances?	○ Yes ○ No	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:_____

Financial Agreement

We are pleased to have an opportunity to provide the highest quality dentistry possible in an open and honest environment based on truth and trust. We will do everything we can to live up to the standards you expect and deserve from us as professionals. Pleases take a moment to read the following:

Payment or estimated co-pay amounts are expected at the time service is provided. We accept cash, checks, all major credit cards, and Care Credit. Payment plans can be arranged in advance with approved credit. There are also several book keeping discount options available upon request.

For those with insurance: I understand that my dental insurance plan is a contract between me and my insurance carrier, and not between my insurance carrier and the practice, and that I am responsible for all dental fees. I assign all of my insurance benefits, otherwise payable to me, to Kenneth E. Henley, D.D.S. at Armbrust Dental, P.C. I understand that the **estimated** payment for the uncovered portion of services rendered must be paid at each visit. I agree that this office accepts the assignment of my Primary insurance benefits for a maximum of 60 days. Please initial _____.

I agree that if, after being properly filed, my insurance company has failed to pay the claim within 60 days, that I will be expected to pay for that visit within 10 days of being billed. I further understand that the **estimated portion** that insurance will pay is just that…**an estimate**. No one can really know for sure what the insurance company will pay.

Refunds: Any personal payment(s) resulting in a credit AFTER insurance has paid will either be refunded in the way of original payment or may remain on the account for future services.

X _____ _____

Signature of patient DATE

Minor patients only: The adult accompanying a minor (under age 18) child to their appointment will be responsible for full payment of the services. Rendered that day unless prior arrangements have been made.

I understand and agree that all services rendered to me or my dependent are charged directly to me. I further understand I am personally responsible for payments. If I suspend or terminate care and treatment, any professional services not yet paid for will be immediately due and payable. Past due balances will be assessed and Billing Charge of 1.5% per month (which is an APR of 18%) after 30 days. In the case of default of payment I promise to pay any legal interest on the balance due, together with any collection agency costs, court costs, and any attorney's fees incurred to effect collection on this account. I have read and understand the financial policy and agree to the terms

X _____ _____

Signature parent or responsible party DATE

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the **Health Insurance Portability and Accountability Act of 1996** ("HIPPA"), I have certain right to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers
- Conduct normal healthcare operations such a quality assessments and physician certifications

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address about to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name (print) _____

Relationship to Patient (other than self) _____

I, _____, DO authorize Armbrust Dental permission to discuss my treatment and all it's regarding with the following people:

1._____ 2._____

Signature (patient or guardian): _____

Date: _____

PHOTO RELEASE

ACCEPT

I, _____, hereby authorize Dr. Kenneth E. Henley to take photographs, slides and /or videos of my face, jaws and teeth. I understand that the photographs, slides and /or videos will be used as a record of my care and may also be used for educational purposes in lectures, demonstrations, advertising(including Armbrustdental.com, Facebook, blogs, newspapers, magazines, phonebooks, television, etc.) as well as professional publications(dental magazines and journals). I do not expect compensation financially or otherwise, for use of these photographs, slides, and /or videos.

DECLINE

I, _____, **DO NOT wish to have my photo's used other than for diagnostic purposes only.**

Three Commitments

We have three important policies in our practice that we feel important to share with you, our valued patient. We have put them in writing because we live by them and require that all our patients live by them as well. We realize that the institution of these three policies may be different from what you may be accustomed to in the past; however, we believe they are very necessary in order for us to provide optimum care to our patients. We ask you to read this page thoroughly and acknowledge your understand of each one by initialing.

Commitment to Treatment Policy

We believe that all treatment begun should be completed. Incomplete treatment leads to problems, complications and misunderstandings. Incomplete treatment leads to loss of teeth and further disease. Therefore, we need to have an understanding that treatment plans, once they are started, will be completed. Some treatment plans, because of their design, take years to complete. However, to begin staged treatment, your commitment to both the starting and completing treatment is required. **Please initial_____**

Commitment to Appointment Policy

We reserve time for each patient in our practice and do not double book except in the case of emergencies. An appointment on our schedule with your name is a bond of trust that we will be here to serve you and you will be present for that appointment. This office reserves the right to deny you the privilege of reserving our time in advance without first paying a deposit, or to make an appropriate charge for missing appointments. **Missed appointments could be subject to a $138 charge without 48 hours' notice.** We understand that situations beyond your control arise and we ask that you do your best to notify us if you are not able to make your appointment(s). Notices must be given by either calling, texting or e-mailing the office Monday-Thursday during normal business hours. Your compliance with this policy indicates that we must have mutual respect for each other's time. **Please initial_____**

Commitment to Financial Agreement

We believe we have a responsibility to use our best professional care, skill and judgment in planning for your dental treatment. The benefits and liabilities of neglect are always explained to you during the explanation of your treatment plan. We both agree that all fees should be properly explained to you and you agree to fulfill you financial commitment to our office promptly and completely. No business or practice can fulfill its mission to its patients when a bond of trust is violated by failure to pay for services in accordance with the financial agreement you signed**. Please initial _____**

Signature X_____ Date _____