Patient registration

DATE_____ NAME_____

PREFERRED NAME_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

HOME NUMBER_____ WORK_____ CELL_____

D.O.B._____ S.S.N.____ ___ ____ AGE _____ MALE__ FEMALE__

MARRIED__ SINGLE__ DIVORCED__ WIDOWED__

EMPLOYER_____

PREVIOUS DENTIST_____ LAST VISIT_____

***A 24 hour notice is required for all cancellations. A $75 fee will be charged to your account if advanced notice is not given.**

Patient signature_____

PATIENT'S SPOUSE IF MARRIED

NAME_____ S.S.N.____ ___ ____ D.O.B._____

EMPLOYER_____ EMPLOYER'S PHONE NUMBER_____

CELL NUMBER _____

IF THE PATIENT IS A MINOR, PLEASE COMPLETE:

FATHER'S NAME_____ S.S.N.____ ___ ____ D.O.B._____

ADDRESS_____ CITY_____ STATE___ ZIP_____

EMPLOYER_____ EMPLOYER'S PHONE NUMBER_____

HOME NUMBER_____ CELL_____

MOTHER'S NAME_____ S.S.N.____ ___ ____
D.O.B._____

ADDRESS_____ CITY_____ STATE___ ZIP_____

EMPLOYER_____ EMPLOYER'S PHONE NUMBER_____

HOME NUMBER_____ CELL_____

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

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, 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 controlled substances?	Yes	No	
Do you need to pre-medicate?	Yes	No	If yes, please explain: _____

Women: Are you 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 If yes, please explain:

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

AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Renal Dialysis	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Rheumatic Fever	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Rheumatism	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Scarlet Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Shingles	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	Hives or Rash	Yes	No	Sickle Cell Disease	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hypoglycemia	Yes	No	Sinus Trouble	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Irregular Heartbeat	Yes	No	Spina Bifida	Yes	No
Asthma	Yes	No	Fainting Spells/Dizziness	Yes	No	Kidney Problems	Yes	No	Stomach/Intestinal Disease	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Leukemia	Yes	No	Stroke	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Liver Disease	Yes	No	Swelling of Limbs	Yes	No
Breathing Problem	Yes	No	Frequent Headaches	Yes	No	Low Blood Pressure	Yes	No	Thyroid Disease	Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Lung Disease	Yes	No	Tonsillitis	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Mitral Valve Prolapse	Yes	No	Tuberculosis	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Pain in Jaw Joints	Yes	No	Tumors or Growths	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Murmur	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disorder	Yes	No	Heart Pace Maker	Yes	No	Radiation Treatments	Yes	No	Yellow Jaundice	Yes	No
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Recent Weight Loss	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 patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

DENTAL INSURANCE

PRIMARY CARRIER

EMPLOYEE_____ D.O.B._____ S.S.N.____ ___ ____

INSURANCE COMPANY_____ I.D. NUMBER_____

GROUP NUMBER_____ INS.PHONE NUMBER_____

SECONDARY CARRIER

EMPLOYEE_____ D.O.B._____ S.S.N.____ ___ ____

INSURANCE COMPANY_____ I.D. NUMBER_____

GROUP NUMBER_____ INS.PHONE NUMBER_____

IF I RECEIVE INSURANCE PAYMENT FOR DENTAL SERVICE PERFORMED AT PLEASANT GROVE FAMILY DENTISTRY, I WILL ENDORSE THE CHECK IMMEDIATELY, ALONG WITH A COPY OF THE E.O.B., TO 4330 MCKNIGHT RD.

X_____

GETTING TO KNOW YOU

IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE? Y__ N__

IF SO, THEIR NAME_____

REFERRED TO US BY_____

PERSON TO CONTACT FOR EMERGENCY_____

PHONE NUMBER_____

ADDRESS_____ CITY_____ STATE___ ZIP_____

CLOSEST RELATIVE NOT LIVING WITH YOU_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

PHONE NUMBER _____

PLEASANT GROVE FAMILY DENTISTRY

Milburn S. Haynes, D.D.S.
Torin M. Marracino, D.D.S.
4330 McKnight Road
Texarkana, Texas 75503
(903) 838-9700

INSURANCE

A. We are happy to accept your co-payment **on the day of service**, file your PRIMARY insurance that same day and wait **six weeks** for insurance payment. We will make ONE inquiry during that time for you if it is not paid within the first 4 weeks. After that time, you will be responsible for the entire balance, as well as further correspondence with YOUR insurance company for reimbursement to you. If you have a secondary policy, we will be happy to file that for YOUR reimbursement, but that estimated payment does not affect your initial co-payment due on the day of service.

B. **What will YOUR particular policy pay?** As a service to you, we study the different plans and attempt to estimate as closely as possible what YOUR policy will pay on each visit. Clinical recommendations for dental appointments may not correspond to insurance payment guidelines. Ex: dental frequency dates and maximums. There are MANY different **insurance companies**, each offering several different **plans**. The various plans have unique USUAL AND CUSTOMARY price allowances (averaged using a formula across urban and rural areas). These many different USUAL AND CUSTOMARY allowances are **set by insurance companies, and do not, in any way, affect our prices.** It is your responsibility to be aware of your personal insurance or Medicaid requirements and to schedule accordingly. You will be required to pay any expenses not covered by your insurance.

After I make the initial estimated co-payment and my insurance responds with a payment or denial, I understand that I may have either a credit or a balance. Even though I have made and initial payment on the charges, I understand that I am responsible for payment of any balance that insurance does not pay.

I hereby authorize payment directly to Pleasant Grove Family Dentistry of the group insurance benefits otherwise payable to me.

By signing this form I am acknowledging that I have read the above information and have been given the chance to ask questions on any information I do not understand.

_____

Signature

Pleasant Grove Family Dentistry
Torin Marracino, D.D.S.
4330 Mc Knight Rd.
Texarkana, Tx.75503

Thank you for choosing Pleasant Grove Family Dentistry as your dental provider. The following is a statement of our Financial Policy, which we require that you read and sign prior to any treatment or office visit.

1. Deductibles, **ESTIMATED** Co-Pays and any uncovered services are due at the time of service. You will be responsible for any remaining Co-Pay after insurance has paid.

2. There will be a charged added to your account on any unpaid balance.

3. You will be considered SELF-PAY until a copy of your insurance is provided.

4. As a **courtesy** we file to your primary and secondary insurance companies, when supplied with the current insurance information.

5. Minor- The adult accompanying the minor will be responsible for payment.

_____ _____

Patient's signature Parent/Guardian Signature (if minor)

_____

Date

PLEASANT GROVE FAMILY DENTISTRY
Torin Marracino, D.D.S.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patient's Name:_____ *Date of Birth*:_____

SSN:_____ *Previous Name*:_____

My personal health information is private and confidential. I understand that my doctor and his staff work very hard to protect my privacy and preserve the confidentiality of my personal health information. I understand that my doctor and his staff may use and disclose my personal health information to help provide health care to me, to handle billing and payment and to take care of other health care operations. There will be no other uses and disclosures of this information unless I permit it. However, I understand that sometimes the law may require the release of this information without my permission. I can ask my doctor to limit how my personal health information is used and disclosed to carry out treatment, payment or health care operations. I understand that my doctor does not have to agree to my request. If my doctor does agree to my request, I understand that my doctor and his staff would follow the agreed limits.
I may cancel this consent at any time by doing the following:

> Writing, signing and dating a letter to my doctor that states that I want to cancel my consent to authorize the use and disclosure of my personal health information for treatment, payment and health care operations.

If I cancel this consent, my doctor and his staff do not have to provide any further health care services to me. My doctor has a detailed document called the Notice of Privacy Practices "Notice". It contains more information about the policies and practices protecting my privacy. I understand that I have the right to read the Notice before signing this agreement. My doctor may update his Notice. If I ask, my doctor or his staff will provide me with the most current Notice. My signature below indicates that I have been given the chance to review a current copy. My signature means that I agree to allow my doctor to use and disclose my personal health information to carry out treatment, payment and health care operations.

I hereby request and authorize the release of all information, without limitations regarding any physical and mental conditions, and revealed by your observation or treatment, past, present or future. This includes medical/dental history, x-ray findings, diagnosis, prognosis and access to all hospital records and photocopies of the same.

I also request the payment of authorized insurance company benefits be made on my behalf to Dr. Milburn Haynes for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to insurance companies or their agents any information needed to determine these benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information needed to pay the claim. Full charges are sent to my insurance company; I am responsible for deductible, coinsurance and non-covered services. Insurance payments and the deductible are based upon the determination of my insurance company and are independent of amounts charged by Pleasant Grove Family Dentistry.

List all family members, friends and/or physicians who are authorized to call and receive test results and information concerning your health care from this facility.

_____

_____ _____
Patient's (or Legal Guardian's) Signature *Date*

_____*Relationship to patient (parent, legal guardian, etc.)*