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: Cell:

Birth Date: Social Security Number: Drivers License Number:

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: Cell:

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

Birth Date: Age: Social Security Number: Drivers License Number:

Email: ◯ I would like to receive correspondences via email

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

Email:

Previous Dentist:

Primary Insurance Information

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

Insured Social Security Number: Insured Birth Date:

Employer: Insurance 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 Social Security Number: Insured Birth Date

Employer: Insurance Company:

Address: Address:

Address 2: Address 2:

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

Rem. Benefits: Rem Deduct:

Sheron Dental

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

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 my 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:

At Sheron Dental, we strive to offer convenient payment options while at the same time maintaining the high standard of comprehensive dental care that our patients deserve. At the onset of your treatment, we will provide you with an estimate of your treatment costs. Our goal is to help you afford your dental choices. Please take a moment to review the three financial options offered at our office:

- **Option A: No Insurance Option/Payment in full on the day of treatment. Bookkeeping courtesy of 5% is given for payment in full by *cash or check* at start of treatment.**

- **Option B: Bill Insurance/Patient Portion paid at the time of service with cash, check, Visa, MasterCard or Debit Card.** **If for any reason the estimated amount is not paid by your insurance company, it becomes your obligation. Please remember that the contract itemizing your dental benefits is between you, your employer and your insurance carrier. Regardless of coverage, your estimated co-payment is due in full the day of treatment. If your dental plan does not pay within 60 days of treatment, you must pay any outstanding balance and seek reimbursement from your dental plan. If your dental plan pays more than expected, you will receive a refund check. Also remember that dental insurance plans are not designed to cover all of your dental needs. Rather, the amount your dental plan contributes towards your dental care is based on the plan selected and purchased by your employer.*

- **Option C: Bill Insurance &/or Payment Plan through CARE CREDIT financing company arranged prior to treatment.**
  - **No initial payment and affordable monthly payments.**
  - **One low monthly payment for multiple family members.**
  - **Prepayments can be made anytime without penalty.**
    Fast, confidential service by phone 1-800-677-0718 or at their secure Website
    www.carecredit.com

Please don't hesitate to contact us if you have questions regarding the payment options described above. We thank you for trusting us with your dental care needs and hope you will let us know if we can improve our service to you in any way.

I, _____, accept full financial responsibility for this account and for all dentistry performed upon my dependents in this dental office. I understand it is my responsibility to confirm insurance eligibility, waiting periods, and benefits. I also understand this office cannot guarantee insurance status in any of these areas. Any insurance estimate or information given to me by this office is not a guarantee of actual insurance payment. I also understand that any insurance claim not paid in full will become my responsibility and interest will accrue at an annual fixed rate of 12% after 60 days. There is a $25 charge for returned checks.

Patient Signature: _____ Date: _____

Office Manager's Approval: _____ Date: _____

MISSED APPOINTMENT POLICY NOTIFICATION

If you are unable to keep your scheduled appointment, please call 360-573-8181 to let us know.

If an appointment is missed or cancelled without 24 hours notice (excluding weekends and holidays) you will be charged. Missed appointments are NOT covered by insurance.

As a courtesy, we send out reminders via text message or e-mail. If these are not preferred, please provide us with the best possible contact number so we may contact you in regards to your appointment.

Exceptions to the charge are made on a case-by-case basis.

Your signature serves as an acknowledgement that you have been informed of the policy. If the patient is a minor, the parent and/or legal guardian is responsible for the charge.

_____

Patient Signature Printed Name Date

SHERON DENTAL

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I, _____ have received a copy of this office's Notice of Privacy Practices.

_____

Please Print Name

_____

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)**

_____

_____

_____

Sheron Dental

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information**. Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.
Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Telephone: 360-573-8181 **Fax: 360-573-8186**

Address: 1200 NE 99th St. Vancouver, WA 98665