Silver Ridge Dental Care -- Patient Registration Form Date: _____

Name: _____ Preferred Name: _____

SS# (for insurance purpose) _____ Date of Birth: _____/_____/_____ License # _____

Circle One: Married Divorced Single Child Male_____ Female_____

Address: _____City: _____ State:_____Zip:_____

**Cell Phone: ( )_____ Home Phone: ( ) _____

**Email Address: _____

Emergency Contact: _____ Phone: _____ Relationship To Pt.: _____

How did you hear about our office? Family/Friend NAME _____ INTERNET SIGN OTHER

If Child, Parent/Guardian Name: _____ Phone: _____ DOB: ____/____/_____

Employment Information for Patient or Guardian if child:

Employer Name: _____ Occupation: _____

Business Phone: ( ) _____ Ext._____ May we contact you at work? Y N

Insurance Information – Please present your insurance card(s) for scanning

*Primary Insurance Company: _____ Plan Name: _____

Policy Holder Name:_____ Is the Policy Holder a Current Patient? Yes No

Policy Holder ID # or SS# _____ Group #_____

Policy Holder Date Of Birth: _____/_____/_____ Policy Holder Employer: _____

Insurance Company Address:_____ City:_____ State:_____ Zip_____

Insurance Company Phone: _____

*Secondary Insurance Company: _____ Plan Name: _____

Policy Holder Name:_____ Is the Policy Holder a Current Patient? Yes No

Policy Holder ID # or SS# _____ Group #_____

Policy Holder Date Of Birth: _____/_____/_____ Policy Holder Employer: _____

Insurance Company Address:_____ City:_____ State:_____ Zip_____

Insurance Company Phone: _____

AFTER READING: PLEASE SIGN AND DATE: _____ **DATE:** _____

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. The office will help prepare the patients insurance claim forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. A service charge of 1 ½% per month (18% annually) on the unpaid balance will be charged on all accounts exceeding 60 days unless previously written financial arrangements are made

SILVER RIDGE DENTAL CARE - HEALTH HISTORY

Patient Name: _____ Phone Number To Reach You: _____

Physician's Name: _____ Date of Last Visit: _____ /_____
Month Year

Are you now under the continued care of a physician? _____Yes _____No

If yes, what condition(s) are you being treated for? _____

Has a physician recommended that you take antibiotics prior to your dental treatment? ___Yes ___No

Past and Current Medical Conditions (Please check ALL that apply)

___AIDS/HIV
___Anemia
___Angina
___Arthritis
___Artificial Joint/Implants/Heart
___Asthma
___Blood Disease
___Bronchitis
___Cancer
___Chronic pain
___Diabetes
___Dizziness
___Epilepsy
___Excessive Bleeding
___Fainting Spells
___Glaucoma
___Growths
___Hay Fever
___Head Injuries
___Heart Disease
___Heart Attack
___Heart Murmur
___High Blood Pressure ___Low Blood Pressure
___Hepatitis
___Kidney Disease
___Liver Disease
___Mental Health Disorders
___Nervous Disorders
___Pacemaker
___Pregnancy Due Date: _____
___Radiation Treatment
___Respiratory Problems
___Rheumatic Fever
___Rheumatism
___Sinus Problems
___Stomach Problems
___Stroke
___Tuberculosis
___Tumors
___Ulcers
___Venereal Disease
___Chemical Dependency / _____Now ____ In the Past

OTHERS NOT LISTED: _____

Medications

List any prescription or over the counter medications you are currently taking (or send list)

Allergies

Are you allergic to or ever had a reaction to: (Please check all that apply)

____Aspirin
____Barbiturates, sedatives, or sleeping pills
____Codeine or other narcotics
____Hay fever / seasonal
____Iodine
____Latex (rubber)
____Local Anesthetic
____Metals
____Penicillin or other antibiotics
____Sulfa drugs

Additional: _____

Note: Both Doctor and Patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient or Legal Guardian: _____ Date: _____

SILVER RIDGE DENTAL CARE

Consent for Service / Fee & Payment Information / Insurance / Appointment Cancellations

Thank you for choosing Silver Ridge Dental Care as your dental provider. We are committed to providing you with the best possible care for you and your family. The following information outlines your responsibility related to office policies for professional services.

As a condition of your treatment by this office, financial arrangements must be made in advanced. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. A service charge of 1 ½% per month (18% annually) on the unpaid balance will be charged on all accounts exceeding 60 days unless previously written financial arrangements are made.

Consent for Treatment: In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breech of any time or condition hereunder shall not constitute a waiver of any further term or condition. I understand should collection become necessary, the responsible party agrees to pay an additional 40% for collection agency fees, costs, and all legal fees of collection, without suit, including attorney fees, court costs and filing fees. If a balance remains unpaid, you/family may be dismissed from this practice.

Emergency Services: All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Dental Insurance: Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. The office will help prepare the patient's insurance claim forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. A service charge of 1 ½% per month (18% annually) on the unpaid balance will be charged on all accounts exceeding 60 days unless previously written financial arrangements are made.

Non-covered Patients: For patients without dental insurance, payment is appreciated at the time of service. Patient will be granted a 10% discount for payment in full on the day of service. Please ask about our payment options for treatment over $200.

Treatment Estimates: Any fee estimates for dental care can only be extended for a period of 90 days unless previously written financial arrangements are satisfied.

Appointment NO-SHOWS: To avoid a cancellation fee, we require a 24 hour notice so that we may attempt to fill that opening. A fee of $40 may be charged for missed appointments with no notice.

Co-payments, deductibles and patient portion will be due at the time of service. For your convenience we accept cash, checks, or credit card. (Visa, MasterCard, Discover, AMX, Care Credit)

I have read the above conditions of treatment, office policies, and payment terms and agree to their content.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party

SILVER RIDGE DENTAL CARE

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received/read and agree to the contents of this office's Notice of Privacy Practices.

Print Name: _____ **Date:** _____

Signature: _____

CONSENT TO SHARE PERSONAL INFORMATION

I agree to allow this person(s) to receive dental and personal information concerning my condition and dental treatment from Silver Ridge Dental Care.

Name: _____ Relationship: _____ Phone: _____

Circle: ALL Information Treatment Info. Insurance Info. X-ray Info. Financial Info. Medical Info.

Name: _____ Relationship: _____ Phone: _____

Circle: ALL Information Treatment Info. Insurance Info. X-ray Info. Financial Info. Medical Info.

Signature of Patient: _____ 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) _____