

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 ☐ FemaleMarital 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** _____**Section 3** _____Employment Status: ☐ Full Time ☐ Part Time ☐ RetiredStudent Status: ☐ Full Time ☐ Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg: _____

Referred By _____

Previous Dentist _____

Emergency Contact _____

Emergency Contact # _____

Receive Text Message _____

Employer _____

Email for reminders _____

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: _____

Eaglesoft 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 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?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Have you ever been hospitalized or had a major operation?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Have you ever had a serious head or neck injury?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Are you taking any medications, pills, or drugs?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Do you take, or have you taken, Phen-Fen or Redux?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Are you on a special diet?	<input type="radio"/> Yes <input type="radio"/> No		
Do you use tobacco?	<input type="radio"/> Yes <input type="radio"/> 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 <input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No	Hemophilia <input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No	Diabetes <input type="radio"/> Yes <input type="radio"/> No	Hepatitis A <input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No	Drug Addiction <input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No
Anemia <input type="radio"/> Yes <input type="radio"/> No	Easily Winded <input type="radio"/> Yes <input type="radio"/> No	Herpes <input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No
Angina <input type="radio"/> Yes <input type="radio"/> No	Emphysema <input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Rheumatism <input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No	High Cholesterol <input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No	Hives or Rash <input type="radio"/> Yes <input type="radio"/> No	Shingles <input type="radio"/> Yes <input type="radio"/> No
Artificial Joint <input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No
Asthma <input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No
Blood Disease <input type="radio"/> Yes <input type="radio"/> No	Frequent Cough <input type="radio"/> Yes <input type="radio"/> No	Kidney Problems <input type="radio"/> Yes <input type="radio"/> No	Spina Bifida <input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No	Leukemia <input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No
Breathing Problems <input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No	Liver Disease <input type="radio"/> Yes <input type="radio"/> No	Stroke <input type="radio"/> Yes <input type="radio"/> No
Bruise Easily <input type="radio"/> Yes <input type="radio"/> No	Genital Herpes <input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No
Cancer <input type="radio"/> Yes <input type="radio"/> No	Glaucoma <input type="radio"/> Yes <input type="radio"/> No	Lung Disease <input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No
Chemotherapy <input type="radio"/> Yes <input type="radio"/> No	Hay Fever <input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No	Tonsillitis <input type="radio"/> Yes <input type="radio"/> No
Chest Pains <input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No	Osteoporosis <input type="radio"/> Yes <input type="radio"/> No	Tuberculosis <input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No	Heart Murmur <input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No	Ulcers <input type="radio"/> Yes <input type="radio"/> No
Convulsions <input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No	Venereal Disease <input type="radio"/> Yes <input type="radio"/> No
			Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> 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: _____

Please ☒ Check any box that applies to you so that we can address any concerns and answer any questions you may have.

- ☐ I am happy with the appearance of my teeth/gums/smile.
- ☐ I would like to discuss enhancing the appearance of my smile (check the following that apply):
 - ☐ I wish my teeth were whiter.
 - ☐ I wish my teeth were straighter.
 - ☐ I do not like the shape of my teeth.
 - ☐ I do not like the size of my teeth (too small or too large).
 - ☐ I have gaps between my teeth that I do not like.
 - ☐ What I do not like about my smile is not listed here.
- ☐ I would like to enhance my smile BUT I am concerned about (check the following that apply):
 - ☐ Cost
 - ☐ Time Required for Treatment
 - ☐ Comfort (fear of dentistry)
 - ☐ I have other concerns about enhancing my smile not listed here.

Let Our Family Make Your Family SMILE!



TODD N. LARRABEE, DDS
KENDRA S. HEEKE, DDS
TERRAH M. LARRABEE, DDS, MSD

HOW DID YOU HEAR ABOUT US?
& APPOINTMENT REMINDERS

How did you hear about our office? Please ☒ Check any box that applies to you.

- ☐ Flyer in the mail
- ☐ Location of office
- ☐ In-Network list from insurance
- ☐ Internet search
- ☐ Facebook / I Heart Spring Hill
- ☐ Friend/Family Member
- ☐ Other

How would you like to receive your appointment reminders? Please ☒ Check one.

- ☐ Email
- ☐ Text Message
- ☐ Both

Let Our Family Make Your Family SMILE!

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand that I may request a copy of the *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that Spring Hill Smiles reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

Patient Name

Date

Signature of Patient / Responsible Party

Relationship to Patient (if other than Self)

It is your right to refuse to sign this Acknowledgement

Dental Office Use Only

I tried to obtain written Acknowledgement by the individual noted above of receipt of our Notice of Privacy Practices, but it could not be obtained because:

An emergency prevented us from obtaining acknowledgment.

A communication barrier prevented us from obtaining acknowledgment.

The individual was unwilling to sign.

Other: _____

Signature of Witness

Date

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. The following is a statement of our financial policy that we would like you to read and sign prior to your treatment.

PAYMENT FOR SERVICES

We expect full payment at the time of service, unless another financial agreement is made in advance. For your convenience, we accept Mastercard, Visa and Discover.

REGARDING INSURANCE

We will gladly file your insurance, as a courtesy to you, but your estimated portion, including co-pays and deductibles, is due at the time services are rendered. Your insurance is a contract between the insurance company, your employer and you. We are, typically, not a party in this contract. Please be aware that some, and perhaps all, of the services we provide to you may be non-covered services and not considered "reasonable and necessary" under your dental insurance. If for any reason your insurance carrier does not pay the full estimated benefit, the remaining portion will become the responsibility of the patient or responsible party.

CANCELLATION POLICY

When we make your appointment, we are reserving a room for your particular needs. If you must change an appointment, we ask that you give us at least two business days. This courtesy makes it possible to give your reserved room to another patient who would like it.

After the second missed appointment, without a two business day notice, we will be unable to reserve a room and time for you. We will however add you to our call list and call you with any appointments that open up the same day. Repeated cancellations or missed appointments will result in loss of future appointment privileges.

LATE PAYMENT PENALTY

Any account 90 days past due will be turned over to collections and will be charged 40% of the balance due for collection fees.

NON-SUFFICIENT FUNDS PENALTY

If payment is made with a check that is declined due to non-sufficient funds, a fee of \$35 will be applied to your account and due, along with the original balance, within 10 days.

CREDIT AGREEMENT

In consideration of the extension of credit to me, I agree to pay attorney's fees and any other expenses incurred in the collection of my account, should I fail to pay as hereby promised.

CONSENT TO RELEASE OF PATIENT INFORMATION AND RECORDS

I hereby give my permission for the release of my records, including but not limited to radiographs, photographs and impressions, for the purpose of professional consultation, referrals to another dental or specialist's office and/or fabrication of dental prosthesis or appliances by dental laboratories. Transmission of these records may be completed via mail, fax and/or unencrypted email. No information obtained from the medical history form will be transmitted via unencrypted email; however, patient name, age, birthdate and gender may be used to identify radiographs and photographs.

Patient Name

Date

Signature of Patient / Responsible Party

Relationship to Patient (if other than Self)