Spring Hill Smiles
LARRABEE FAMILY DENTISTRY & ORTHODONTICS

TERRAH M. LARRABEE, DDS, MSD

NEW PATIENT REGISTRATION

Please review and make any necessary changes as well as fill in any missing information. Thank you!

What brings you in today? _____

Patient Name: _____

Preferred Name: _____

Gender: _____

Patient Date of Birth: _____

Phone Numbers

Home: _____

Office: _____

Cell: _____

Address

_____

_____

Email Address: _____

Primary Insurance Information

Insurance Company: _____

Name of Insured: _____

Insured Social Security Number: _____

Insured Date of Birth: _____

Employer: _____

Relationship to Insured: _____

Secondary Insurance Information

Insurance Company: _____

Name of Insured: _____

Insured Social Security Number: _____

Insured Date of Birth: _____

Employer: _____

Relationship to Insured: _____

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NEW PATIENT REGISTRATION

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

- [x] Referred by Dr. _____
- [x] Flyer in the mail
- [x] 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

*Please verify that you have provided the appropriate email or cell phone number for these reminder messages on the first page.

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NEW PATIENT REGISTRATION

All About Me Questions:

What school do you attend? _____

Do you play sports? _____

Do you have any hobbies? _____

What is your favorite color? _____

What is your favorite food? _____

Do you have any pets? _____

What is your favorite Television show? _____

What fun activities do you like to do on the weekends? _____

Do you have any brothers or sisters? _____

If so, what are their names and ages? _____

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MEDICAL HISTORY

Patient Name: _____

CURRENT OR PREVIOUS MEDICAL CONDITIONS:

- ☐Y ☐N Abnormal bleeding
- ☐Y ☐N Allergies to any drugs
- ☐Y ☐N Allergies to Latex or Metals
- ☐Y ☐N Allergies to Plastics
- ☐Y ☐N Asthma
- ☐Y ☐N Cancer
- ☐Y ☐N Congenital Heart Defects
- ☐Y ☐N Convulsions/Epilepsy
- ☐Y ☐N Diabetes
- ☐Y ☐N Endocarditis (history of)
- ☐Y ☐N Handicaps/Disabilities
- ☐Y ☐N Hearing Impairment
- ☐Y ☐N Heart Murmur
- ☐Y ☐N Hemophilia
- ☐Y ☐N Hepatitis
- ☐Y ☐N HIV+/AIDS
- ☐Y ☐N Joint Replacement
- ☐Y ☐N Kidney/Liver Problems
- ☐Y ☐N Operations or Hospitalizations
- ☐Y ☐N Rheumatic Fever/Scarlet Fever
- ☐Y ☐N Tuberculosis
- ☐Y ☐N Adenoids or tonsils removed?
- ☐Y ☐N Any pain/tenderness in jaw joint?
- ☐Y ☐N Any current dental pain?

OTHER:

- ☐Y ☐N Injuries to the face, mouth, teeth, jaw or chin?
- ☐Y ☐N Does the patient play a musical instrument?
- ☐Y ☐N Speech problems?

CURRENT OR PREVIOUS HABITS:

- ☐Y ☐N Smoking
  If Previous, Age Habit Stopped: ___
- ☐Y ☐N Smokeless Tobacco
  If Previous, Age Habit Stopped: ___
- ☐Y ☐N Clenching/Grinding teeth
- ☐Y ☐N Lip Sucking/Biting
- ☐Y ☐N Mouth Breathing
- ☐Y ☐N Nail/Pen/Pencil/Object Biting
- ☐Y ☐N Thumb/Finger Sucking
  If Previous, Age Habit Stopped: ___

CHILD OR ADOLESCENT PATIENTS:
In order to determine if growth potential still remains, please answer the following:

- ☐Y ☐N Has the patient reached puberty (males) or menarche/first menstrual period (females)?
  If yes, approximately how long ago? _____

Please explain any medical, mental or emotional conditions:

Please list any drugs the patient is currently taking:

- ☐Y ☐N Does the patient take a prophylactic antibiotic prior to dental treatment?

General Dentist: _____
Last Dental Visit (Date and Procedure): _____

- ☐Y ☐N Has the patient had any previous orthodontic treatment?
- ☐Y ☐N Has the patient had any previous orthodontic consultations?

I hereby certify that I have reviewed the above medical/dental history and that it is accurate to the best of my knowledge at this time. If there are any future changes in the information, I will inform Dr. Terrah M. Larrabee and/or the staff at Spring Hill Smiles immediately.

_____ October 6, 2015
Signature of Patient / Responsible Party — Date

_____
Print Name of Responsible Party (if other than Self)

Spring Hill Smiles
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TERRAH M. LARRABEE, DDS, MSD

HIPAA NOTICE OF PRIVACY PRACTICES

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 acknowledgement.
- ☐ The individual was unwilling to sign.
- ☐ Other: _____

_____ _____

Signature of Witness Date

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OFFICE AND FINANCIAL POLICY

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 24 hours notice. This courtesy makes it possible to give your reserved room to another patient who would like it.
After the second missed appointment, without 24 hours notice, a $25 fee will be applied to your account.
Repeated cancellations or missed appointments will result in loss of future appointment privileges.

LATE PAYMENT PENALTY

Any account 30 days past due will be assessed a late charge of 1.5%. An additional late charge of 1.5% will be assessed each month after that until payment is made and the account is current.

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)

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.