Patient Registration

Patient Information:

First Name:_____Last Name:_____Middle Intial:_____

Preferred Name:_____Date of Birth:_____

Address:_____

City:_____State:_____Zip:_____

Social Security:_____Drivers License:_____

Home Phone:_____Work:_____

Cell Number:_____Female:____ or Male:____

Email Address:_____

Responsible Party: (if someone other than the patient)

First Name:_____Last Name:_____Middle Intial:_____

Preferred Name:_____Date of Birth:_____

Address:_____

City:_____State:_____Zip:_____

Social Security:_____Drivers License:_____

Home Phone:_____Work:_____

Cell Number:_____

Primary Insurance Information:

Name of Insured:_____Relationship to Insured:_____

Name of Insurance Company:_____

Insured ID number:_____Group number:_____

Insured Date of Birth:_____Employer:_____

Please provide us with your Photo ID and Insurance Card.

Notice of Privacy Practices

I understand that, under the Heath Insurance Portability & Accountability Act of 1996(HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

*Conduct, plant, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly
*Obtain payment from third-party payers
*Conduct normal healthcare operations, such as quality assessments and physician certifications.

I have received, read, and understand our Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact them to obtain a current copy of the Notice of Private Practice.

Patient Name:_____

Relationship to Patient:_____

Signature:_____Date:_____

Opelika Dental Associates requests that each patient sign this consent form, which allows us to share protected health information with family members such as a spouse, a parent, or others who call and request information. By signing this form, you consent to our use and disclosure of protected information about your treatment. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize Opelika Dental Associates to release protected information to the following individuals.

1._____relationship to patient:_____Date:_____

2._____relationship to patient:_____Date:_____

3._____relationship to patient:_____Date:_____

Office Policy

Our Policy Requires:

-Appointment Confirmation: We asked that if we give you a courtesy reminder call please call us back to confirm your appointment.

-Timely Cancellations: If you need to cancel or reschedule your appointment, you must give us at least 24 hours' notice. We will charge **a $25 broken appointment fee** for missed appointments. We do understand that unforeseen circumstances do arise and we will take this into consideration.

-On Time Arrivals: if you are more than 15 minutes late to your appointment, we will have to reschedule. This will be considered a broken appointment and subject to $25 broken appointment charge.

Patient Signature:_____Date:_____

Insurance Acceptance Agreement and Non Covered Service Policy/Agreement to Pay

I authorize the release of any information necessary to process my dental claims and request payment of benefits to Opelika Dental Associates for dental services rendered. I understand that the insurance benefits given to me at the time of service are only an estimate, and that I am responsible for the entire balance of my account after insurance has/has not paid. A finance charge will be applied to overdue balances. There may be certain services that you need or desire that are not covered by your dental insurance.. Only services that are necessary and appropriate for each patient's treatment will be performed.

Agreement to Pay: I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, (33.33%), attorney fees and/or court costs, if such be necessary.

Consent to contact by cell phone. You agree, in order for us to service your account or to collect monies you may owe, Opelika Dental Associates and/or our agents may contact you by telephone at any number associated with your account including wireless telephone, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

I have read the Insurance Acceptance Agreement and Non Covered Services Policy and agree, as indicated by the signature below, to pay for services that are not covered or for which payment is not allowed by my contract: I have read this disclosure and agree that Opelika Dental Associates, it employees and/or agent may contact me/us as described above.

Signature:_____Date:_____

Personal Information Date: _____

Mr./Mrs./Miss: _____ DOB: _____ SSN: _____
Last Name First Name Middle Initial

Home Address: _____ City/State: _____ Zip: _____

Home Phone Number: _____ Cell Phone Number: _____ Work Phone Number: _____

Occupation: _____ Employer: _____ Email: _____

Person Financially Responsible: _____ Relationship to Patient: _____ SSN: _____

Billing Address: _____City/State: _____ Zip: _____

Dental Insurance _____ Group/Plan Number: _____

Insurance Address:
_____

Spouse Name: _____ Employer: _____ SSN: _____

Referred from: _____
I authorize, Forest Park Smiles on 11th to furnish information to insurance carriers concerning my treatments and I assign to Forest Park Smiles on 11th all payments or dental services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance the day services are rendered, and further agree to a credit history check if deemed necessary. In the event of NONPAYMENT, I further agree to bear the cost of collection and/or court cost and reasonable legal fee should this be required.

Signature: _____
(A photocopy of this form shall be deemed as valid and effective as the original)

Medical History

1. Have you been hospitalized or had a serious illness within the past within the past 5 years? If yes, explain: _____
   _____
2. Do you take, or have you recently taken any medication or drugs? If so, please list:
   _____
   _____
3. Have you ever had any ALLERGIC or ADVERSE REACTIONS to anesthetics, antibiotics, aspirin, codeine, or other medication?
   If so, please list: _____
4. Have you had abnormal bleeding with previous extractions, surgery, or trauma? _____
5. Have you ever been tested for HIV infections? (AIDS)? Yes / No If yes, result of test Date: _____ Positive / Negative

6. Do you have or have had any of the following:
    - High Blood Pressure
    - Heart murmur or prolapsed valve
    - Joint prosthesis (Hip, Knee, etc.)
    - Rheumatic fever
    - Hepatitis
    - Cardiovascular disease: Heart attack, stroke, by-pass, etc.
    - Pacemaker
    - Tuberculosis
    - Diabetes
    - Epilepsy
7. Are you REQUIRED TO PERMEDICATE WITH ANTIBIOTICS prior to dental treatment? _____
8. Are you pregnant? _____
9. Do you take birth control pills? _____ If yes, be advised that if you take antibiotics, an alternative method of birth control must be used.

TO THE BEST OF MY KNOWLEDGE, ALL THE PRECEDING ANSWES ARE TURE. IF I EVER HAVE ANY CHANGE, I WILL INFORM THE DOCTOR AT MY NEXT APPOINTMENT.

Signature of patient or legal guardian: _____

Medical History

Patient Name:_____Date:_____

Indicate which of the following conditions you have had or currently have by checking beside each condition.

____Pre-Med for Dental TX	____Head Injuries	____Dizziness
____Allergy to Latex	____Pacemaker	____Respiratory Problems
____Epilepsy	____Cancer/Tumor	____Clotting Disorder
____High Blood Pressure	____Heart Disease	____Asthma
____Stroke	____Mental Disorder	____ Artificial Joints
____Excessive bleeding	____Hepatitis A/B/C	____Sinus Problems
____HIV	____Diabetes	____Tuberculosis
____Currently pregnant	____ Fainting	____Nervous Disorder

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing Bisphosphonates?

Yes_____No_____

Are you currently taking any medications? If so please list below or provide the office with a list of medications.

_____

_____

_____

_____

By Signing below, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. If there are other medical conditions or medications/allergies that have not been listed I must give that information and any other changes in the future.

Signature_____