

Patient Registration

Patient Information:

First Name: _____ Last Name: _____ Middle Initial: _____

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 Initial: _____

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 Health 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, plan, 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: _____

Medical History

Patient Name: _____ Date: _____

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

- | | | |
|--|--|---|
| <input type="checkbox"/> Pre-Med for Dental TX | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Allergy to Latex | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Cancer/Tumor | <input type="checkbox"/> Clotting Disorder |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Mental Disorder | <input type="checkbox"/> Artificial Joints |
| <input type="checkbox"/> Excessive bleeding | <input type="checkbox"/> Hepatitis A/B/C | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> HIV | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Currently pregnant | <input type="checkbox"/> Fainting | <input type="checkbox"/> 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 _____