New Smiles Dental Excellence

PATIENT REGISTRATION FORM

Patient Information

Patient Name: _____

Address: _____ Apt: _____

City: _____State:_____ Zip: _____ DOB:_____

How long at this address: _____ Home Phone#:_____ Cell#:_____

Email Address: _____

Preferred Contact method: _____ Social Sec#:_____ DL#_____

Responsible Party Information (If same as above you can skip)

Name: _____

Address: _____ Apt:_____

City: _____State:_____ Zip: _____

How long at this address: _____ Home Phone#:_____ Cell#:_____

Email Address: _____

Preferred Contact method: _____ Social Sec#:_____ DL#_____

Insurance Information: **Insurance/Dental Plan: Please provide your copy of insurance card or provide your details below**

Primary Insurance: PPO DMO

Plan Name: _____ Insurance/Plan Phone#:_____

Address: _____ City, State, Zip_____

Employer: _____ Group#_____

Plan#_____ Insured Name: _____

Insured Soc.Sec#_____ Birth Date_____

Emergency Contacts

Name: _____ Phone#:_____

Physician Name: _____ Phone#:_____

Getting to know you:

Do you have family members who may need dental care? If so, please list name & relationship (son, daughter, and spouse)

1._____ 2._____ 3._____ 4. _____

How did you hear about our office? (Circle one)

◯ Family Friend ◯ Direct Mail Postcard ◯ Internet Search ◯ Website

◯ Flyer-Coupon ◯ Office Sign ◯ Insurance Plan/Directory ◯ Zocdoc.com

◯ Other, Please specify referral: _____

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General Health Information

Dental History:

1. Reason for Visit/main Concern? Check Up Cleaning Tooth ache Other_____
2. Are there other conditions of which we should be aware Yes No If yes, specify?
3. When did you last visit a dentist? _____
4. What treatment was performed? _____
5. Was the treatment completed? _____
6. When were dental x-rays taken? _____
7. Did you have a cleaning? Yes Non
8. Have you had gum (periodontal) treatment? Yes No
9. Have you ever had prolonged bleeding after an extraction? Yes No If yes, specify:_____
10. Have you ever had any problems with past dental treatment? Yes No if yes, specify?
11. Do you grind your teeth, clinch jaws, or have symptoms near your ears such as clicking, popping, pain or locking open? Yes No if yes, specify:_____
12. Have you ever been diagnosed or treated for TMD (Temporomandibular Joint Dysfunction) sometimes called TMJ? Yes No if yes, specify:_____
13. Do your gums bleed easily? Yes No
14. Do you feel you have bad breath? Yes No
15. Are your teeth sensitive to hot or cold? Yes No
16. Would like your teeth whiter? Yes No
17. Are you happy with your smile? Yes No, if no, specify:_____

Medical History

1. Are you under Doctor's care at this time? Yes No if yes, specify_____
   Dr. Name: _____ Dr. Phone: _____
2. Are you allergic to penicillin, codeine, local anesthetics, tranquilizers or any other drugs or medicine?_____
3. Are you taking any medications at this time, If you are a Woman including birth control? Yes No
4. (Woman) Are you pregnant at this time? Yes No if yes, please specify how many months:_____
5. Are there any other health problems of which we should be advised? Please specify:_____
6. Do you have or have you had any of the following?

Please circle YES or NO

Artificial Heart Valve	Yes or No	Dizzy/Fainting	Yes or No	Kidney Disease	Yes or No
AIDS/HIV	Yes or No	Drug Addiction	Yes or No	Latex Allergy	Yes or No
Anemia	Yes or No	Emphysema	Yes or No	Liver Problems	Yes or No
Angina	Yes or No	Epilepsy	Yes or No	Low BP	Yes or No
Arthritis	Yes or No	Glaucoma	Yes or No	Lung Disease	Yes or No
Asthma	Yes or No	Heart Surgery	Yes or No	Pacemaker	Yes or No
Bleeding Problems	Yes or No	Heart Murmur	Yes or No	Phen-Fen	Yes or No
Cancer	Yes or No	Hepatitis	Yes or No	Psychiatric Care	Yes or No
Chemo/Rad Therapy	Yes or No	High BP	Yes or No	Rheumatic Fever	Yes or No
Cosmetic Surgery	Yes or No	Jaundice	Yes or No	Sinus Problems	Yes or No
Diabetes	Yes or No	Joint replacement	Yes or No	Sleep Apnea	Yes or No
Stroke	Yes or No	Thyroid Problems	Yes or No	Tuberculosis	Yes or No
Venereal Disease	Yes or No	Other conditions: Please list if any:_____			

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any changes with my health and or/medication. I consent to a complete evaluation, including x-rays.

Signature (Parent if patient is minor):_____ Date:
Doctor Signature: _____ Date

Health Information Privacy Policies & Procedures

These Health Information Privacy Policies & Procedures implement our obligations to protect the privacy of individually identifiable health information that we create, receive, or maintain as a healthcare provider.

We implement these Health Information Privacy Policies and Procedures as a matter of sound business practice; to protect the interests of our patients; and to fulfill our legal obligations under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), its implementing regulations at 45 CFR Parts 160 and 164 (65 Fed. Reg 82462 (Dec. 28, 2000)) ("Privacy Rules"), as amended (67 Fed. Reg. 53182 [Aug. 14, 2002]), and state law that provides greater protection or rights to patients than the Privacy Rules.

As a member of our workforce or as our Business Associate, you are obligated to follow these Health Information Privacy Policies & Procedures faithfully. Failure to do so can result in disciplinary action, including termination of your employment or affiliation with us.

These Policies & Procedures address the basics of HIPAA and the Privacy Rules that apply in our dental practice. They do not attempt to cover everything in the Privacy Rules. The Policies & Procedures sometimes refer to forms we use to help implement the policies and to the Privacy Rules themselves when added detail may be needed.

Please note that while the Privacy Rules speak in terms of "individual" rights and actions, these Policies & Procedures use the more familiar word "patient" instead; "patient" should be read broadly to include prospective patients, patients of record, former patients, their authorized representatives, and any other "individuals" contemplated in the Privacy Rules.

If you have questions or doubts about any use or disclosure of individually identifiable health information or about your other obligations under these Health Information Privacy Policies & Procedures, the Privacy Rules or other federal or state law, please contact our office.

Dr. Manjula Alapati
New Smiles Dental Excellence
Policy adopted on July 11, 2013

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement*

_____

Signature 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: Circle/check mark appropriate below.

- ◯ Individual refused to sign
- ◯ Communications barriers prohibited obtaining the acknowledgement
- ◯ An emergency situation prevented us from obtaining acknowledgement
- ◯ Other (Please Specify)_____

New Smiles Dental Excellence

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. 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. **All emergency dental services, or any dental services performed, must be paid for in full at the time services are performed.**

Insurance: New Smiles Dental Excellence provides insurance company billing as a courtesy to our patients; payment is due after 60 days of service for any reason if Insurance Company fails to adjudicate the claim in a reasonable manner. The patient portion of particular dental service(s) is estimated and due at the time of service. This amount may be subject to adjustment when the dental service(s) claim(s) are adjudicated by the insurance company. In addition, certain insurance companies have annual limitation for the amount of dental services that can be reimbursed within each plan year. If you or your family exceed these annual limitations in any plan year, you will be responsible for the full amount of dental services that exceed the particular plan's limitations. The patient is responsible for monitoring the amount of his/her remaining benefits for any annual benefit period. The patient may not rely upon any information provided by New Smiles staff regarding his/her remaining benefit in any such benefit period. The claims we submit to insurance companies indicate that you have assigned those benefits to New Smiles. However, if you are paid by the insurance company instead of New Smiles, you then become responsible for the total account balance and payment would be expected immediately. If you or your family has more than one dental insurance program, we will assist you in obtaining the maximum benefits available. You as a patient are always responsible for any charges that are not covered by your insurance.

Most misunderstandings about insurance can be avoided if you understand what your policy provides. Many insurance policies pay according to a schedule of benefits that is based on a various criterion. This office charges fees which are reasonable in this community. **Not all insurance companies will pay 100% of our charges. The patient (and/or spouse/guarantor) is responsible to pay all sums unpaid by insurance**. Benefits are only determined once a claim is received by the insurance company, there are NO verbal guarantees given by the insurance company. Any determination of benefits verbally and/or written given by any staff member is not guaranteed.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days. Unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of 6 months from the date of the patient's examination.

If you are unable to keep your appointments we require 24 hour notice for cancellations. If you give less than 24 hours' notice there will be a $100 charge for appointments scheduled longer than 1.5 hours. If appointment scheduled is less than 1.5 hours there will be a $40 charge.

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 her/his assignee at the time said services are rendered or within 5 days of billing if credit shall be extended.

I further agree that the reasonable value said services shall be billed unless objected to, by me in writing within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. If it becomes necessary to collect any sum due through an attorney, then the patient (and/or spouse/guarantor) agrees to pay all costs of collection, including attorney's fees.

I grant my permission to you or your assignee, to call me at home or at work to discuss matters related to this form.

The patient/legal guardian authorizes the release of information acquired in the course of treatment as necessary to file insurance claims. I have read the above conditions of treatment and payment and agree to their content.

Signature of guarantor of payment/responsible party **Date:**
Print Name: **Date:**
Relationship to Patient: