PATIENT REGISTRATION

LEGAL FIRST NAME: _____

LEGAL LAST NAME: _____

MIDDLE INITIAL: _____ PREFERRED NAME: _____

RESPONSIBLE PARTY IS: ☐ SELF ☐ OTHER: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: (_____) _____

WORK PHONE: (_____) _____ EXT. _____

CELL PHONE: (_____) _____

CELL PHONE CARRIER: _____ (ex. AT&T, Verizon, etc.)

APPOINTMENT CONTACT PREFERENCES:

☐ CALL ME (PREFERRED NUMBER: ☐ HOME ☐ WORK ☐ CELL)

☐ TEXT ME ☐ SORRY, I CAN'T RECEIVE TEXTS ON MY CELL PHONE

☐ EMAIL ME: _____

I AM:

☐ MALE ☐ FEMALE

☐ SINGLE
☐ MARRIED
☐ DIVORCED
☐ SEPARATED
☐ WIDOWED

BIRTHDATE:

__ __ / __ __ / __ __ __ __

SOCIAL SECURITY:

__ __ __ - __ __ - __ __ __ __

DRIVER'S LICENSE NUMBER

_____

For Office Use Only

☐ *Insurance Card(s) Scanned*
☐ *Driver's License Scanned*

As a courtesy, The Smile Shack will process your dental claims for you. If you would like to opt in for this service, it is vital that ALL of the information requested below is provided prior to your first/next visit. If your information is incomplete or faulty, the obligation to file your dental claims reverts back to the responsible party. ☐ **I have read and agree to these terms.**

PRIMARY DENTAL INSURANCE COMPANY _____ GROUP No. _____

RELATIONSHIP to POLICY HOLDER: ☐ **SELF** ☐ **SPOUSE** ☐ **CHILD** ☐ **OTHER** INS. PHONE: (_____) _____

INS. ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

POLICY HOLDER'S NAME: _____ EMPLOYER: _____

MEMBER ID: _____ SSN: _____ BIRTHDATE: _____

MEMBER ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE: (_____) _____ SPECIAL NOTE: _____

OFFICE USE ONLY: ☐ *INSURANCE VERIFIED* *ANNUAL DEDUCTIBLE $* _____ *ANNUAL RENEWAL DATE:* ___/___/___

SECONDARY DENTAL INSURANCE COMPANY _____ GROUP No. _____

RELATIONSHIP to POLICY HOLDER: ☐ **SELF** ☐ **SPOUSE** ☐ **CHILD** ☐ **OTHER** INS. PHONE: (_____) _____

INS. ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

POLICY HOLDER'S NAME: _____ EMPLOYER: _____

MEMBER ID: _____ SSN: _____ BIRTHDATE: _____

MEMBER ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE: (_____) _____ SPECIAL NOTE: _____

OFFICE USE ONLY: ☐ *INSURANCE VERIFIED* *ANNUAL DEDUCTIBLE $* _____ *ANNUAL RENEWAL DATE:* ___/___/___

3839 JAMES COURT • ZANESVILLE, OHIO 43701 • PHONE: (740) 454-4112 • FAX (740) 454-4922 • EMAIL: THESMILESHACK@RROHIO.COM

MEDICAL HISTORY

PATIENT NAME: _____ BIRTH DATE: _____

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? ☐ Yes ☐ No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ☐ Yes ☐ No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No _____

Are you on a special diet? ☐ Yes ☐ No _____

Do you use tobacco? ☐ Yes ☐ No _____

Do you use controlled substances? ☐ Yes ☐ No _____

Women: Are you

Pregnant? ☐ Yes ☐ No Trying to get pregnant? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Other

If yes, please explain: _____

Do you have or have you had any of the following?

☐ Yes ☐ No AIDS/HIV Positive
☐ Yes ☐ No Alzheimer's Disease
☐ Yes ☐ No Anaphylaxis
☐ Yes ☐ No Anemia
☐ Yes ☐ No Angina

☐ Yes ☐ No Arthritis/Gout
☐ Yes ☐ No Artificial Heart Valve
☐ Yes ☐ No Artificial Joint
☐ Yes ☐ No Asthma
☐ Yes ☐ No Blood Disease

☐ Yes ☐ No Blood Transfusion
☐ Yes ☐ No Breathing Problem
☐ Yes ☐ No Bruise Easily
☐ Yes ☐ No Cancer
☐ Yes ☐ No Chemotherapy

☐ Yes ☐ No Chest Pains
☐ Yes ☐ No Cold Sores/Fever Blisters
☐ Yes ☐ No Congenital Heart Disorder
☐ Yes ☐ No Convulsions
☐ Yes ☐ No Cortisone Medicine

☐ Yes ☐ No Diabetes
☐ Yes ☐ No Drug Addiction
☐ Yes ☐ No Easily Winded
☐ Yes ☐ No Emphysema
☐ Yes ☐ No Epilepsy or Seizures

☐ Yes ☐ No Excessive Bleeding
☐ Yes ☐ No Excessive Thirst
☐ Yes ☐ No Fainting Spells/Dizziness
☐ Yes ☐ No Frequent Cough
☐ Yes ☐ No Frequent Diarrhea

☐ Yes ☐ No Frequent Headaches
☐ Yes ☐ No Genital Herpes
☐ Yes ☐ No Glaucoma
☐ Yes ☐ No Hay Fever
☐ Yes ☐ No Heart Attack/Failure

☐ Yes ☐ No Heart Murmur
☐ Yes ☐ No Heart Pace Maker
☐ Yes ☐ No Heart Trouble/Disease
☐ Yes ☐ No Hemophilia
☐ Yes ☐ No Hepatitis A

☐ Yes ☐ No Hepatitis B or C
☐ Yes ☐ No Herpes
☐ Yes ☐ No High Blood Pressure
☐ Yes ☐ No Hives or Rash
☐ Yes ☐ No Hypoglycemia

☐ Yes ☐ No Irregular Heart Beat
☐ Yes ☐ No Kidney Problems
☐ Yes ☐ No Leukemia
☐ Yes ☐ No Liver Disease
☐ Yes ☐ No Low Blood Pressure

☐ Yes ☐ No Lung Disease
☐ Yes ☐ No Mitral Valve Prolapse
☐ Yes ☐ No Pain in Jaw Joints
☐ Yes ☐ No Parathyroid Disease
☐ Yes ☐ No Psychiatric Care

☐ Yes ☐ No Radiation Treatment
☐ Yes ☐ No Recent Weight Loss
☐ Yes ☐ No Renal Dialysis
☐ Yes ☐ No Rheumatic Fever
☐ Yes ☐ No Rheumatism

☐ Yes ☐ No Scarlet Fever
☐ Yes ☐ No Shingles
☐ Yes ☐ No Sickle Cell Disease
☐ Yes ☐ No Sinus Trouble
☐ Yes ☐ No Spina Bifida

☐ Yes ☐ No Stomach/Intestinal Disease
☐ Yes ☐ No Stroke
☐ Yes ☐ No Swelling of Limbs
☐ Yes ☐ No Thyroid Disease
☐ Yes ☐ No Tonsillitis

☐ Yes ☐ No Tuberculosis
☐ Yes ☐ No Tumors or Growths
☐ Yes ☐ No Ulcers
☐ Yes ☐ No Venereal Disease
☐ Yes ☐ No Yellow Jaundice

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes, please explain: _____

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 Date

The Smile Shack • 3839 James Court, Suite 12 • Zanesville, OH 43701 • Ph: (740) 454-4112 • Fax: (740) 454-4922

FINANCIAL AGREEMENT

THANK YOU!! For choosing The Smile Shack for your dental needs. Our GOAL is to provide you and your family with the Best Quality Care available, while simultaneously fostering a Great Relationship. To make this goal a reality takes Commitment from Everyone. Here's how…

YOU CAN HELP!!

PAYMENTS

To maintain the outstanding care you receive and prevent potential misunderstandings, we ask all of our patients to agree and adhere to paying for their dental treatment at the time of service. With this agreement in place, our relationship **WILL FLOURISH!!**

WE ACCEPT:

- **CASH/CHECKS** – Patients who are self-pay will receive a **5% DISCOUNT** when treatment is paid **IN FULL** by cash or check **AT THE TIME OF SERVICE**.
- **CREDIT/DEBIT CARD** – We accept VISA and MasterCard, as well as HSA/Flex Cards.
- **CARECREDIT** – CareCredit is a healthcare credit card that makes your treatment possible today!! It is designed for your health, beauty, and wellness needs. With many special financing options, you can avoid paying interest by making minimum monthly payments and paying the full amount due by the end of the promotional period. See **www.carecredit.com** for more details.

INSURANCE

If you have dental benefits, congratulations!! You are very fortunate. Here are some important things you should know…

- **BENEFITS** – Keep in mind that dental benefits do not typically cover the entire cost of treatment. They work more like a scholarship. They are there simply to assist you financially.
- **ESTIMATES** – We will do our best to accurately estimate your patient portion based on the most up-to-date information we have. But, it is only an estimate!! Insurance companies will make their payment determinations based on factors we may not be aware of.
- **RESPONSIBILITY** – If you choose, we will bill your insurance company as a courtesy to you. However, the responsibility to pay is between you and your insurance company. We suggest you take as much interest in making sure your insurance company follows through with their obligation to you as we do. Remember, ultimately you and only you are responsible for all charges incurred in our office.

☐ **I have read and I agreed to honor this financial agreement.**

PRINT NAME: _____

SIGN NAME: _____ **DATE:** _____

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ACKOWLEDMENT RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

I **acknowledge** that I have been provided a copy of **The Smile Shack**'s Notice of Privacy Practices which has an effective date of ____/____/____ and which describes how my health information may be used or disclosed.

I understand that you have the right to change the Notice of Privacy Practices at any time, that I will be provided a copy of any updated version and that I may contact you at any time to request a current Notice of Privacy Practices.

My signature below acknowledges that I have

1. Been provided with a copy of the Notice of Privacy Practices
2. Been offered and refused a copy of the Notice of Privacy Practices
3. Been directed to review the poster of the Notice of Privacy Practices

_____ _____

Signature of patient or patient's representative Date

_____

Print name

_____

Relationship to patient (If not signed by the patient)

Medical Information Release Form (HIPAA Release Form)

Name: _____ Date of Birth: _____/____/_____

[ ] I authorize the release of information including appointments, diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____
[ ] Child(ren)_____
[ ] Other_____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Signed: _____ Date: ____/____/_____
Witness:_____ Date: ___/____/_____