PATIENT REGISTRATION

Patient Name (Last, First, Middle Initial)	Date of Birth	Social Security Number	Gender Male Female Marital Status Single Married
Address	City	State	Zip
Home Phone: **W**ork Phone: **C**ell Phone:	What name do you prefer to be called? E-Mail Address (print clearly)		
Preferred method of Confirmation: ___ Phone call **Circle Best Contact: **H W C** ___ Text ___ Email			
Employer	Occupation	Relationship to Insured SELF SPOUSE CHILD OTHER	

PRIMARY DENTAL INSURANCE CARRIER **SECONDARY DENTAL INSURANCE CARRIER**

Name of Policy Holder		Name of Policy Holder	
Date of Birth		Date of Birth	
Insurance Company Name		Insurance Company Name	
Member I.D. #	Group Number	Member I.D. #	Group Number
Employer	Occupation	Employer	Occupation

WHO SHOULD BE NOTIFIED LOCALLY IN CASE OF EMERGENCY?

Name	Phone

REFERRED TO THIS OFFICE BY:

Friend/Family Member: (so we can thank them)_____

Walk in Internet Insurance List Sign Out Front

Signature_____ Date_____

OFFICE NOTES

_____

_____

_____

Patient Name

PATIENT MEDICAL HISTORY

Your comfort and good dental health are dependent upon an accurate knowledge of your medical well-being. Many medical situations can affect or be affected by procedures or drugs used for dentistry. Therefore, please fill out the following carefully. THANK YOU.

HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS? Please **X** If Yes

Latex Allergy	☐	Kidney Disease	☐	Emotional Concerns/Psychiatric Care	☐
Hepatitis	☐	Fainting or Dizziness	☐	Chronic Sinus Problems	☐
Glaucoma	☐	Heart Attack	☐	Thyroid Condition	☐
Epilepsy	☐	Stroke	☐	Bleeding or Blood Problem	☐
Diabetes	☐	High Blood Pressure	☐	Herpes Simplex I (canker sores)	☐
Asthma	☐	Low Blood Pressure	☐	AIDS or AIDS Related Complex	☐
Alcoholism	☐	Stomach Ulcer	☐	Malignancies or Tumors	☐

	YES	NO
• Have you experienced an unusual or allergic reaction to any of the following: Penicillin, Codeine, Aspirin or any other drug?……	☐	☐
• Have you ever experienced an unusual reaction to Dental Anesthetics(Novacaine)	☐	☐
• Have you had any prosthetic surgery such as: artificial heart valve replacement or an artificial hip or joint replacement?……	☐	☐
• Have you received or are you currently receiving medication known as bisphosphonates (for example, zoledronic acid [Zometa] or pamidronate [Aredia]?	☐	☐
• Are you under any medical treatment or taking medication now?……	☐	☐
• Are you now or ever been treated with chemotherapy or radiation?.....	☐	☐
• Do you smoke?..... Packs per day ____……	☐	☐
• Are you pregnant (women) Y☐ N☐ …… Birth control medication…	☐	☐

If you have marked any of the above with a yes, please give us a brief history:

_____

_____

Name of Physician: _____ Phone: _____

DENTAL HISTORY

How long has it been since your last dental cleaning?_____

What did you like most about your previous dentist?_____

What did you like least?_____

What are you expecting today? _____

Do you have any pain in your jaw upon opening or closing?_____Tension Headaches?_____

Signature_____ Date_____Updated _____

DES MOINES DENTAL CENTER
FINANCIAL AGREEMENT AND POLICIES

It is our optimal goal to provide you and your family with the highest quality of dental care while maintaining a friendly and relaxing environment. In order to keep our standard of care at a level which best serves your dental needs, we ask you to please observe the following guidelines:

OUR FINANCIAL POLICY:

Your portion of the payment is due at the time that services are rendered.
For your convenience, we offer several payment options: We accept Cash, Checks (NSF Fee $75.), or Visa/Mastercard, Discover, American Express. We offer extended payment plan with prior credit approval. (Care Credit)

REGARDING INSURANCE:

Insurance coverage is a valuable asset in restoring and maintaining good oral health. By providing us with accurate insurance information, you enable us to process your claims in a timely manner. It is the patient's responsibility to update the office with changes in your insurance company or policy. Our office is not a party to that contract and final responsibility of payment is yours. With current insurance information, we strive to determine benefits prior to treatment, which provides you with important deductible and co-payment information. As a courtesy to you, we will help process your insurance claims. **We accept assignment of insurance benefits; however we do require your co-payment and deductibles to be paid at time of service. The balance is your responsibility whether your insurance company pays or not**. If there is no payment from the insurance company with sixty (60) days, you will be expected to pay the balance in full. All accounts over ninety days (90) days will be subject to a finance charge of 1.0% per month, which is an annual rate of 12%

MEDIA USAGE:

I hereby permit Des Moines Dental Center to use any and all media forms including, but not limited to, photographs, copy, and x-rays for use on the Des Moines Dental Center web site and other web sites belonging to Steven M Reeves, DDS

CANCELLATION POLICY:

There are many times when our patients require urgent or emergency treatment and therefore need an appointment as soon as possible. When patients give the office advance notice of their need to cancel a scheduled appointment, this time can then be allocated to those patients with immediate needs. In this way the office can best serve the needs of ALL patients. Bearing this in mind, our office requires a minimum of 48 business hours notice if an appointment must be cancelled. If less than 48 business hours notice has been given to cancel an appointment, a $75 per hour fee will be assessed.

We at the Des Moines Dental Center look forward to taking care of your oral health needs and welcome you and your family to our team of dental professionals.

I have read the above policies of the Des Moines Dental Center and understand my responsibilities as a patient.

Patient Signature_____Date_____

Des Moines Dental Center
PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

• Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);

•Obtaining payment from third party payers (e.g. my insurance company);

• The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.
I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.
I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____day of _____ 20_____.

Print Patient Name _____

Signature _____

Relationship to Patient _____