Rock Run Dental Patient Registration

Patient Full Name: _____ Preferred Name: _____

Street Address: _____ Home Phone: _____

Work Phone: _____EXT_____

(City, State, Zip)_____ Cell Phone: _____

☐ I would like to receive text messages to remind me of my appointment
(Standard text messaging rates will apply)

PO Box: _____

(City, State, Zip): _____ Email: _____

Drivers License #: _____ ☐ I would like to receive an Email to remind me of my appointment

Gender: M / F Date of Birth: _____ SSN: _____ - _____ - _____ Marital Status: S M D W

Responsible Party

(*If other than patient)*

Name: _____ Relation to Patient: _____

Street Address: _____ Home Phone: _____

(City, State, Zip) _____ Work Phone: _____EXT_____

Date of Birth: _____ SSN: _____- _____- _____ Cell Phone: _____

Drivers License #: _____ Email: _____

Employer: _____ Years Employed: _____ Marital Status: S M D W

Spouse / Significant Other

Name: _____ Relation to Patient: _____

Street Address: _____ Home Phone: _____

(City, State, Zip) _____ Work Phone: _____EXT_____

Date of Birth: _____ SSN: _____ - _____- _____ Cell Phone: _____

Drivers License #: _____ Email: _____

Employer: _____ Years Employed: _____ Marital Status: S M D W

Primary Dental Insurance

Subscriber: _____ Employer: _____

Insurance Company: _____ ID #: _____

Address: _____ Policy Holder SSN: _____

(City, State, Zip) _____ Policy Holder Date of Birth: _____

Ins. Co. Phone #: _____ Group #: _____

Secondary Dental Insurance

Subscriber: _____ Employer: _____

Insurance Company: _____ ID #: _____

Address: _____ Policy Holder SSN: _____

(City, State, Zip) _____ Policy Holder Date of Birth: _____

Ins. Co. Phone #: _____ Group #: _____

Referral Information/ Emergency Contacts

Whom may we thank for your referral: _____

Please provide the following information for emergency contact purposes

Nearest Relative NOT living with you: _____ Phone: _____ Relation: _____

Adult Friend: Phone:

Medical History

Physicians Name: _____ Phone: _____

Are you currently under a physician's care: Y N Reasons: _____

Have you ever been hospitalized or had a major operation: Y N Reasons: _____

Have you ever had a serious head or neck injury: Y N

List ALL medications that you are now taking: _____

_____

Have you ever taken Phen-Fen or Redux: Y N
Have you ever taken Fosomax, Boniva, Actonel or any other bisophonate Y N
Are you on a special diet: Y N
Do you use tobacco: Y N
Do you use controlled substances: Y N

WOMEN: Are you pregnant: Y N Are you taking oral contraceptives: Y N Are you nursing: Y N

Are you allergic to any of the following: ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthesia ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs
☐ Other _____

Do you have, or have you had, any of the following:

☐ AIDS/ HIV Positive	☐ Cortisone Medication	☐ Hemophilia	☐ Radiation Treatments
☐ Alzheimer's Disease	☐ Diabetes	☐ Hepatitis A	☐ Recent Weight Loss
☐ Anaphylaxis	☐ Drug Addiction	☐ Hepatitis B or C	☐ Renal Dialysis
☐ Anemia	☐ Easily Winded	☐ Herpes	☐ Rheumatic Fever
☐ Angina	☐ Emphysema	☐ High Blood Pressure	☐ Rheumatism
☐ Arthritis/Gout	☐ Epilepsy or Seizures	☐ High Cholesterol	☐ Scarlet Fever
☐ Artificial Heart Valve	☐ Excessive Bleeding	☐ Hives or Rash	☐ Shingles
☐ Artificial Joint	☐ Excessive Thirst	☐ Hypoglycemia	☐ Sickle Cell Disease
☐ Asthma	☐ Fainting Spells/Dizziness	☐ Irregular Heartbeat	☐ Sinus Trouble
☐ Blood Disease	☐ Frequent Cough	☐ Kidney Problems	☐ Spina Bifida
☐ Blood Transfusion	☐ Frequent Diarrhea	☐ Leukemia	☐ Stomach/Intestinal Disease
☐ Breathing Problem	☐ Frequent Headaches	☐ Liver Disease	☐ Stroke
☐ Bruise Easily	☐ Genital Herpes	☐ Low Blood Pressure	☐ Swelling of Limbs
☐ Cancer	☐ Glaucoma	☐ Lung Disease	☐ Thyroid Disease
☐ Chemotherapy	☐ Hay Fever	☐ Mitral Valve Prolapse	☐ Tonsillitis
☐ Chest Pains	☐ Heart Attack/Failure	☐ Osteoporosis	☐ Tuberculosis
☐ Cold Sores/Fever Blisters	☐ Heart Murmur	☐ Pain in Jaw Joints	☐ Tumors or Growths
☐ Congenital Heart Disorder	☐ Heart Pace Maker	☐ Parathyroid Disease	☐ Ulcers
☐ Convulsions	☐ Heart Trouble/Disease	☐ Psychiatric Care	☐ Venereal Disease ☐ Yellow Jaundice

Any other serious illness not listed above: _____

Dental History

When was your last dental appointment? _____
When was your last dental hygiene/cleaning appointment? _____
Were x-rays taken Yes / No
When was the last time you had a panoramic or full mouth series x-ray taken_____
How often do you visit the dentist and hygienist for regular checkups? _____

Do you know what periodontal charting/probing is? Yes / No
Have you ever had periodontal charting/probing done? Yes / No
Have you ever been diagnosed with periodontal disease? Yes / No
-If yes have you ever had Periodontal Scaling or Root Planing Yes / No
Have you ever been given additional home care instructions? Yes / No

On a scale of 1-10 how do you rate your smile? _____
Is there anything you would change about your smile? Yes / No
- If yes- What would it be?_____

If you do not remember the last time you had x-rays please provide your previous dentist name & number. _____

HIPAA Disclaimer

The Health Insurance Portability and Accountability Act (HIPAA) requires all health care records and other individually identifiable health information, disclosed in any form, to be kept confidential. We respect our legal obligation to keep health information that identifies you private. Without specific written authorization, we are permitted to disclose your health information for treatment, payment, or health care operations.

You can obtain a copy of the HIPAA privacy practice at our office. It will be available at your request.

Financial Information

In accordance with the Federal Truth in Lending Act which requires us to give you the information in connection with the extension of credit, please be advised of the following policies in this office. The responsible party agrees to:

1. Pay the doctor in full at the time of treatment or by previous arrangement.
2. Co-pays are due at the time of service.
3. I agree to pay all amount(s) owed within 30 days of when such amount(s) are incurred. I understand that it is my responsibility to provide my correct/updated insurance information, and that this office will bill my insurance as a courtesy to me. However, regardless of insurance coverage, I agree that it is and shall remain my responsibility to pay all amounts owing as set forth herein. I agree that interest will accrue on all past-due amounts at the rate of 18% per annum (1.5% per month) until paid in full. In the event any amount(s) is/are referred to a third party debt collection agency, I agree that in addition to any other amount(s) allowed for by law, (such as interest, court cost, reasonable attorney's fees, etc.) I will also be responsible for a collection fee up to 33% of the principal amount(s) owing as allowed by Utah Code Annotated, sec. 12-1-11. The terms of this paragraph shall apply to all amount(s) incurred by me or by any individual for whom I have legal responsibility whether such amount(s) are incurred today or after today.
4. I hereby consent to being contacted by telephone at any telephone number (including but not limited to wireless/cellular phone numbers) provided by me or anyone associated with me or acting on my behalf to Rock Run Dental or anyone acting on its behalf. I understand and agree that such calls may be initiated by Rock Run Dental or any of its affiliates, agents, contractors or assigns, including but not limited to billing companies and/or third-party collection agency(ies) and that the methods of contact may include using pre-recorded/artificial voice messages and/or the use of automated dialing device or/or the use of text messages-some or all of which may result in data charges. I also consent to receiving e-mails at any email address provided by me or anyone associated with me or acting on my behalf.
5. Utah law requires Rock Run Dental to provide the responsible party with notice, by certified mail, priority mail, or text message 60 days prior to placing any delinquent balance with a collection agency or reporting any delinquent balance to any credit bureau, which actions may negatively impact my credit score. I understand that I will be charged a fee of $10 if any such notice is sent to me.

- I understand that insurance is a contract between the policyholder and the insurance company. I understand and take full responsibility for full payment on my account of any unpaid balance. I understand that insurance claims pending for longer than 90 days will be closed, and payment will then become my responsibility. I understand that any coordination of benefits with my insurance is my responsibility, and upon notification, must be taken care of within 10 business days.

- Your appointment is reserved especially for you. Failure to provide 24 hours notice for cancellation will result in a fee of $75.

I understand that by signing this financial authorization I agree to the above terms set into effect as of July 12, 2017.

Authorization

- I authorize the staff to perform any necessary dental treatment and do voluntarily assume the possible risks associated with the procedures.

- I understand the above information and guarantee that this form is complete and accurate to the best of my knowledge. I understand that it is my responsibility to inform our office of any changes that occur with the information that I have provided.

Signature for this information will be required at the time of your visit.

Signature _____ Date:_____