TIME 09:01 AM DATE 10/2/2015

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: [ ] Policy Holder [ ] Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

[ ] Responsible Party is also a Policy Holder for Patient [ ] Primary Insurance Policy Holder [ ] Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: [ ] Male [ ] Female Marital Status: [ ] Married [ ] Single [ ] Divorced [ ] Separated [ ] Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: [ ] I would like to receive correspondences via e-mail.

Section 2

Employment Status: [ ] Full Time [ ] Part Time [ ] Retired

Student Status: [ ] Full Time [ ] Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

Emergency Contact

Emergency Contact #

Mom`s Cell #

Dad`s Cell #

Guardians Cell #

EMPLOYER:

2

Primary Insurance Information

Name of Insured: Relationship to Insured: [ ] Self [ ] Spouse [ ] Child [ ] Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: [ ] Self [ ] Spouse [ ] Child [ ] Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Eaglesoft Medical History(Copy)

Patient Name: Birth Date: Date Created:

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 currently under physician care? Please list your physician's name.	Yes	No	If yes
Have you ever been hospitalized or had a major operation? Explain.	Yes	No	If yes
Have you ever had a serious head or neck injury? Explain.	Yes	No	If yes
Are you taking any medications, pills, or drugs? Please List.	Yes	No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	Yes	No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes	No	If yes
Are you on a special diet? Explain.	Yes	No	If yes
Do you use tobacco? How much?	Yes	No	If yes

Women: Are you...

Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin	Penicillin	Codeine	Acrylic
Metal	Latex	Sulfa Drugs	Local Anesthetics

Other allergies not listed above? Please List.	Yes	No	If yes
Do you use controlled substances/medications?	Yes	No	If yes

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

AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Radiation Treatments	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Recent Weight Loss	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Renal Dialysis	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Rheumatic Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Rheumatism	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	High Cholesterol	Yes	No	Scarlet Fever	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hives or Rash	Yes	No	Shingles	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Hypoglycemia	Yes	No	Sickle Cell Disease	Yes	No
Asthma	Yes	No	Fainting Spells/Dizziness	Yes	No	Irregular Heartbeat	Yes	No	Sinus Trouble	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Kidney Problems	Yes	No	Spina Bifida	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Leukemia	Yes	No	Stomach/Intestinal Disease	Yes	No
Breathing Problems	Yes	No	Frequent Headaches	Yes	No	Liver Disease	Yes	No	Stroke	Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Low Blood Pressure	Yes	No	Swelling of Limbs	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Lung Disease	Yes	No	Thyroid Disease	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Mitral Valve Prolapse	Yes	No	Tonsillitis	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Osteoporosis	Yes	No	Tuberculosis	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Murmur	Yes	No	Pain in Jaw Joints	Yes	No	Tumors or Growths	Yes	No
Congenital Heart Disorder	Yes	No	Heart Pacemaker	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No
Yellow Jaundice	Yes	No									

Have you ever had any serious illness not listed	Yes	No	If yes

Comments:

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:

X Date:_____

Good Life Dental, P.C.
Dr. Kate Wolford, D.D.S.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(You may refuse to sign this acknowledgement.)

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____

Print Name

_____

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:

- ○ Individual refused to sign
- ○ Communications barriers prohibited obtaining the acknowledgement
- ○ An Emergency situation prevented us from obtaining acknowledgement
- ○ Other (Please specify)

_____

_____

_____

Good Life Dental, P.C.
Dr. Kate Wolford, D.D.S.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Name: _____ Birth Date: _____

Address: _____

Telephone number: _____

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Good Life Dental, P.C.
302 South Bailey
North Platte, NE 69101
Phone: (308) 532-0427
Fax: (308) 532-9410

Right to Revoke: You have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

Good Life Dental, P.C.
Dr. Kate Wolford, D.D.S.
302 South Bailey
North Platte, NE 69101
(308) 532-0427

FINANCIAL POLICY

We would like to provide you with the best possible dental care. If you wish to receive an estimate of the charges for your care, we will gladly provide this for you before we begin. The cost of your care depends on which services you receive. In many cases there is more than one choice that can be made. When there is more than one option we will provide you with those additional estimates. Estimates are valid for 60 days from the date of the exam.

Our policy is payment in full at time of services. When extensive treatment is needed we request that we receive 50% down payment prior to starting treatment, with the remainder of the balance due within 30 days of completing treatment. Any payment arrangements must be approved before treatment is started. If you need to extend payment beyond 30 days the account will be subject to additional fees and finance charges. The finance charge will be 1.33% monthly or 16% APR (annual percentage rate) on the unpaid balance. We do offer in house payment plans if needed. If it becomes necessary to collect your account through a collections agency, you will be liable for the additional collections fees and finance charges. Failure to keep your account current may delay your treatment.

We will gladly process your primary insurance claims for you. If you have insurance we require you to pay your estimated patient portion and/or deductible at the time of service. You need to be aware that this is only an estimate of what your insurance will cover, they may pay more or they may pay less. If your insurance company pays you directly, full payment is due when services are provided. We do not file secondary insurance; we will provide you with information needed after your primary insurance claim has been paid. In most cases, insurance carriers prefer to receive a pre-determination claim prior to starting any procedures over a specific dollar amount. A pre-determination claim works the same as providing you with an estimate. It allows the insurance company, the dentist and you to know how much they plan to pay on your behalf before we begin treatment.

YOU MUST REALIZE THAT:

- Your insurance is a contract between YOU, YOUR EMPLOYER, AND THE INSURANCE COMPANY. We are not a party to that contract.
- Your policy may base its allowable charges on a schedule which may or may not coincide with current acceptable fees in our area. Insurance companies vary greatly in the types of coverage available.
- Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
- While filing claims is a courtesy that we extend to you, all charges are YOUR responsibility from the date the services are rendered. Your statement will show all charges. If your insurance company has made a payment to us, it will show on your statement.

Your employer or your insurance company can provide you with a booklet that outlines your coverage. Insurance companies provide you with Customer Service Representatives to explain allowable charges; you should contact the insurance company.

If you have any questions about the above information, please ask us.
I have read and agreed to the above polices. We will provide a copy of this policy upon request of the responsible party.

Date:_____ **Patient Signature:**_____

If you are signing as a personal representative of the patient, describe your relationship to the patient.

Relationship to Patient: _____

Print Name: _____

Signature of responsible party: _____