ID: _____ **Chart ID:** _____

PATIENT REGISTRATION

First Name _____ Last Name_____ Middle Initial _____

Patient is: ☐ Policy Holder ☐ Responsible Party Preferred First Name _____

Responsible Party

First Name _____ Last Name_____ Middle Initial _____

Address 1 _____ Address 2 _____

City, State, ZIP _____

Home (_____) _____-_____ Cell (_____) _____-_____ Work (_____) _____-_____ _____

Birth Date _____/_____/_____ Soc Sec _____-_____-_____ Drivers Lic#/State _____ _____

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

Patient Information

First Name _____ Last Name_____ Middle Initial _____

Address 1 _____ Address 2 _____

City, State, ZIP _____

Home (_____) _____-_____ Cell (_____) _____-_____ Work (_____) _____-_____ _____

Email _____ ☐ I would like to receive correspondence by email

Birth Date _____/_____/_____ Soc Sec _____-_____-_____ Drivers Lic#/State _____ _____

Sex ☐ Male ☐ Female Marital Status ☐ Married/Dom Partner ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Employment ☐ FT ☐ PT ☐ Retired ☐ Unemployed ☐ House Spouse ☐ N/A Student ☐ FT ☐ PT ☐ N/A

Medicaid ID _____ Employer ID _____ Carrier ID _____

Preferred Dentist _____ Preferred Hygenist _____

Pharmacy _____

Referred by _____ Prev Dentist_____

Emergency Contact Name _____ Phone (_____) _____-_____

Primary Insurance Information

Name of Insured _____ Relationship to Insured ☐ Self ☐ Spouse/Dom Par ☐Child ☐ Other

Insured SSN _____-_____-_____ Insured Birth Date _____/_____/_____

Employer _____ Ins. Company _____

Address 1 _____ Address 1 _____

Address 2 _____ Address 2 _____

City/State/Zip _____ City/State/Zip _____

Rem. Benefit _____ Rem. Deductible _____

Secondary Insurance Information

Name of Insured _____ Relationship to Insured ☐ Self ☐ Spouse/Dom Par ☐ Child ☐ Other

Insured SSN _____-_____-_____ Insured Birth Date _____/_____/_____

Employer _____ Ins. Company _____

Address 1 _____ Address 1 _____

Address 2 _____ Address 2 _____

City/State/Zip _____ City/State/Zip _____

Rem. Benefit _____ Rem. Deductible _____

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 list_____

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

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ Yes ☐ No

Are you on a special diet? ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No Women only ☐ Pregnant/Trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives

Do you use controlled substances? ☐ Yes ☐ No

Are you allergic to any of the following? ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Sulfa Drugs ☐ Other-please explain:

_____

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

Do you have, or have you had, any illness not listed above? ☐ No ☐ Yes If yes, please explain_____

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 _____ Date _____/_____/_____

Financial Agreement

This financial agreement is between Ellen A Sheridan, D.D.S. 104 Archibald St, Kansas City, MO 64111 816-531-0382 and

_____, the responsible party for

the patient _____.

If you have dental benefits, we will help you receive maximum benefits by filing for you. We will expect payment of estimated copays, coinsurance and deductibles at the time of service. We accept Mastercard, Visa, Check and Cash. Financing is offered through Care Credit.

As a patient (or guardian of a patient) I understand that this office does not acknowledge agreements between parents accepting or denying responsibilities of services provided. We consider the custodial guardian/parent to be responsible for payment of services received.

Assignment of Insurance Benefits I hereby assign benefits to be paid, on my behalf, to Ellen A. Sheridan, D.D.S. I understand and agree to be financially responsible for charges not covered or paid by dental benefits.

By entering my name below I acknowledge the above financial agreement.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ Date _____/_____/_____

Notice of Privacy Practices Acknowledgement

I understand that. under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

• Conduct plan and direct my treatment and follow-up among the multiple healthcare providcrs who may be involved in that treatment directly and indirectly.

• Obtain payment from third-party payers.

• Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received. read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ Date _____/_____/_____