Patient Registration Form

PATIENT INFORMATION

Name: _____ _____ _____ Mr. Mrs. Ms. Dr.
LAST FIRST MI CIRCLE ONE

Address: _____ _____ _____ _____
NUMBER & STREET CITY STATE ZIP

(___) _____ (___) _____ (___) _____
HOME PHONE WORK PHONE CELL PHONE

M F _____ ___/___/___ _____
SEX MARITAL: M D S W DOB SOCIAL SECURITY NUMBER

_____ _____ _____
EMAIL ADDRESS OCCUPATION EMPLOYER

INSURANCE INFORMATION

Employer: _____ _____
COMPANY NAME ADDRESS - NUMBER & STREET

Address: _____ _____ _____ (___) _____
CITY STATE ZIP EMPLOYEE PHONE

_____ _____
GROUP NUMBER ID NUMBER

_____ _____
INSURANCE COMPANY NAME INSURANCE COMPANY ADDRESS - NUMBER & STREET

_____ _____ _____ (___) _____
CITY STATE ZIP INSURANCE PHONE NUMBER

RESPONSIBLE PARTY INFORMATION

_____ _____ M F
RESPONSIBLE PARTY OCCUPATION EMPLOYER SEX

Name: _____ _____ _____
LAST FIRST MI CIRCLE ONE

Address: _____ _____ _____ _____
NUMBER & STREET CITY STATE ZIP

(___) _____ (___) _____ _____ _____
HOME PHONE CELL PHONE SOCIAL SECURITY NUMBER BIRTHDAY

ADDITIONAL INFORMATION

Spouse: _____ ___ ___/___/___ _____ (___) _____
FIRST NAME MI DOB SOCIAL SECURITY # CELL PHONE

_____ _____
SPOUSE OCCUPATION EMPLOYER

AUTORIZATION & RELEASE: I authorize Cleveland Dental Associates to release any information, including the diagnosis and the records of any treatment examination rendered to me or my child during the period of such dental care, to the third party payers and/or healthcare practitioners. I authorize Cleveland Dental Associates to evaluate me credit record through any credit reporting agencies. I authorize and request my insurance company to pay directly to the dentist or dental group dental benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. All accounts that are past 30 days will be subject to a 1.5% monthly balance charge (18%) yearly, plus all cost of collections, if necessary.

Signature:_____ Date:_____

Cleveland Dental Associates
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clevelanddental@gmail.com

CLEVELAND DENTAL
★ ASSOCIATES ★
281-592-5865

Patient name:_____

Do you currently or have you ever...

____ Abnormal Bleeding	____ Head Injuries	____ Rheumatism
____ Alcohol Abuse	____ Heart Disease	____ Sinus Problems
____ AIDS or HIV+	____ Heart Murmur	____ Stomach Problems
____ Alzheimer's Disease	____ Artificial Heart Valve	____ Stroke
____ Anemia	____ Hepatitis A, B, C	____ Thyroid Disease
____ Arthritis/ Gout	____ High Blood Pressure	____ Tuberculosis
____ Artificial Joints	____ Irregular Heart Beat	____ Ulcers
____ Asthma/ COPD	____ Jaundice	____ Venereal Disease
____ Bacterial Endocarditis	____ Kidney Disease	____ Aspirin Allergy
____ Blood Disease	____ Liver Disease	____ Codeine Allergy
____ Cancer	____ Mental/ Nervous Issue	____ Erythromycin Allergy
____ Blood Thinner	____ Mitral Valve Prolapse	____ Metal Allergy
____ Diabetes	____ Pacemake	____ Latex Allergy
____ Dizziness	____ Pregnancy (Currently)	____ Penicillin Allergy
____ Dry Mouth	*Due Date:_____	____ Sulfa Allergy
____ Drug Abuse	____ Radiation Treatment	____ Local Anesthetics Allergy
____ Epilepsy	____ Chemotherapy	____ Other Allergy:
____ Fainting	____ Respiratory Problems	_____
____ Glaucoma	____ Rheumatic Fever	_____

Have you ever taken bisphosphonates, a class of drugs used to treat osteoporosis or bone cancer?
(Boniva, Fosamax, Actonel, Didronel, Skelid, Aredia, Zometa) YES NO

List all medications, supplements, or drugs that you are currently taking:

Reason for taking medication:

_____ → _____
_____ → _____
_____ → _____
_____ → _____
_____ → _____
_____ → _____

Please continue to the back of the page....

Have you ever had a complication following dental treatment?: **YES** **NO**

If yes, please explain:_____

Have you been admitted to a hospital or emergnecy room in the past two years?: **YES** **NO**

If yes, please explain:_____

Are you under the care of a physician? **YES** **NO**

If yes, please explain:_____

Name of your medical doctor: _____ Phone: _____

Do you smoke or chew tobacco? **YES** **NO**

Do you have health problems that need further clarification? **YES** **NO**

Email: _____ Phone #: _____

Address: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

X_____ _____

Signature of patient, parent, or guardian Date

It's absolutely great to see you today!

CONSENT FOR SERVICES

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.
All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account.

However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. A service charge of 1½ % per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. Accounts that are more than 90 days past due will be sent to a collection agency and assessed a 39% collection fee.

I understand that the fee estimate listed for this dental care can only be extended for a period of three months from the date of the patient examination.

I have read and understand the notice of Privacy Practices at Cleveland Dental Associates.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.
I have read the above conditions of treatment and payment and agree to their content.

_____	_____
Print Name:	Print Name
X_____	X_____
Signature of patient, parent or guardian	Signature of guarantor of payment /responsible party
Date:_____	Date:_____
Relationship to patient:_____	Relationship to patient: _____

HIPAA NOTICE OF PRIVACY

Please Read Carefully

You understand that, as part of the provision of healthcare services, the doctor creates and maintains health records and other information describing among other things, your health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. You have been provided with a notice of privacy practices that provides a more complete description of the uses and disclosures of certain health information. You understand that you have the right to review the notice prior to signing this consent. You understand that the doctor reserves the right to change his/her notice and practices and prior to implementation will mail a copy of any revised notice to the address you have provided. You understand that you have the right to object to the use of your health information for directory purposes.

You understand that you have the right to request restrictions as to how your health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc.) and that the doctor is not required to agree to the restrictions requested. By signing this form, you consent to the use and disclosure of protected health information about the patient for the purposes of treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where disclosures have already made in reliance on your prior consent.

This consent is given freely with the understanding that: a) Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without your prior written authorization, except as otherwise provided by law b) a photocopy or fax of this consent is as valid as the original c) You have the right to request that the use of your Protected Health Information, which is used or disclosed for the purposes of treatment, payment of health care operations be restricted. You also understand that the doctor and you must agree to any restriction in writing that you request on the use and disclosure of your Protected Health Information; and agree to terminate any restrictions in writing on the use and disclosure of your Protected Health Information, which have been previously agreed upon.

Signature_____ Date_____

CLEVELAND DENTAL
* ASSOCIATES *

Financial Arrangement Agreement

We are committed to providing you with the best possible dental care and are pleased to discuss any of our fees at any time. Your clear understanding of our Financial Arrangement Form is very important to our relationship. If you have any questions or concerns, please ask one of our qualified team members.

We request that you settle your account by paying for treatment *at the time service is rendered*. For your convenience we accept cash, personal checks, Visa, MasterCard, Discover, American Express and Care Credit.

Insurance - Your insurance benefits are determined by your employer, not your dentist. Insurance is not a guarantee of payment; they will not pay for all your costs. Your insurance policy is a contract between you and your insurance company. Your insurance and personal payment portion is still your responsibility. As a courtesy we will file your insurance claim for you if you bring: 1) your dental insurance wallet card and 2) all required employer information. If our office is unable to verify your insurance information before treatment, you will be expected to pay for services in full on the day of your visit. *If payment for completed services has not paid in full within 45 days, either by you or your insurance company, the remaining balance for treatment is considered due and collectible.*

Financial Arrangements - Financial arrangements must be determined before any treatment begins and will only be extended to patients having major comprehensive dental treatment. We have several options available, which will be discussed when you meet with a treatment coordinator prior to beginning treatment. Balances on completed treatment over 45 days will be assessed a *$50 late fee*. Balances on completed treatment over 90 days will be turned over to collections.

New Patient/Urgent Appointments -We will be happy to make an appointment for you and to take care of your treatment needs. For these specific appointments, payment will be collected *IN FULL* at the time of service until you are established in our practice as a participating patient. Once established, regular payment policies will apply.

Missed Appointments/Short Notice Cancelations - Appointments are reservations made exclusively for you, therefore, we request a 48-hour notice if you are unable to keep your scheduled appointment. If canceled or missed, the time is taken away from other patients who are waiting to be placed in our schedule. We reserve the right to charge and collect fees for appointments that are canceled or missed without 48 hours advanced notice. A phone call and/or letter will be extended to patents who do not show for their appointment. A short notice cancelation or missed appointment will be assessed a $75 fee if not reappointed within 30 days. Subsequent short notice missed appointments will automatically be assessed the $75 fee. If a reservation deposit is required for your appointment, the full amount will be applied to the appointment. If the appointment is canceled short notice, the deposit is forfeited.

_____ X_____ _____

Print Name Signature Date