

PATIENT REGISTRATION

ID: _____ Chart ID: _____

First Name: _____ Last Name: _____ Middle Initial: _____

Patient Is: Policy Holder Preferred Name: _____
 Responsible Party

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

Section 3

Employment Status: Full Time Part Time Retired

ss: _____

Student Status: Full Time Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

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: _____ .00 Rem. Deduct: _____ .00

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: _____ .00 Rem. Deduct: _____ .00

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

- Are you under a physician's care now? Yes No If yes
- Have you ever been hospitalized or had a major operation? Yes No If yes
- Have you ever had a serious head or neck injury? Yes No If yes
- Are you taking any medications, pills, or drugs? Yes No If yes
- Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No If yes
- Do you use tobacco? Yes No
- Are you anxious about dental treatment? Yes No
- Are you happy with your smile? Yes No
- Do you Pre-med for dental treatment? Yes No
- Do you snore? Yes No
- Do you feel tired a lot? Yes No
- Has anybody observed you quit breathing during your sleep? Yes No

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

- Do you use controlled substances? Yes No If yes
- Other? If yes

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

- | | | | |
|--|---|---|--|
| AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No | Cortisone Medicne <input type="radio"/> Yes <input type="radio"/> No | Hemophilia <input type="radio"/> Yes <input type="radio"/> No | Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No |
| Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No | Diabetes <input type="radio"/> Yes <input type="radio"/> No | Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No | Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No |
| Drug Addiction <input type="radio"/> Yes <input type="radio"/> No | Hepatitis B or C or A <input type="radio"/> Yes <input type="radio"/> No | Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No | Anemia <input type="radio"/> Yes <input type="radio"/> No |
| Easily Winded <input type="radio"/> Yes <input type="radio"/> No | Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No | Angina <input type="radio"/> Yes <input type="radio"/> No | Emphysema <input type="radio"/> Yes <input type="radio"/> No |
| High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No | Rheumatism <input type="radio"/> Yes <input type="radio"/> No | Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No | Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No |
| Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No | Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No | Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No | Hives or Rash <input type="radio"/> Yes <input type="radio"/> No |
| Shingles <input type="radio"/> Yes <input type="radio"/> No | Artificial Joint <input type="radio"/> Yes <input type="radio"/> No | Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No | Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No |
| Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No | Asthma <input type="radio"/> Yes <input type="radio"/> No | Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No | Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No |
| Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No | Blood Disease <input type="radio"/> Yes <input type="radio"/> No | Frequent Cough <input type="radio"/> Yes <input type="radio"/> No | Kidney Problems <input type="radio"/> Yes <input type="radio"/> No |
| Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No | Leukemia <input type="radio"/> Yes <input type="radio"/> No | Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No | Breathing Problems <input type="radio"/> Yes <input type="radio"/> No |
| Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No | Liver Disease <input type="radio"/> Yes <input type="radio"/> No | Stroke <input type="radio"/> Yes <input type="radio"/> No | Bruise Easily <input type="radio"/> Yes <input type="radio"/> No |
| Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No | Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No | Cancer <input type="radio"/> Yes <input type="radio"/> No | Lung Disease <input type="radio"/> Yes <input type="radio"/> No |
| Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No | Chemotherapy <input type="radio"/> Yes <input type="radio"/> No | Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No | Chest Pains <input type="radio"/> Yes <input type="radio"/> No |
| Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No | Osteoporosis <input type="radio"/> Yes <input type="radio"/> No | Tuberculosis <input type="radio"/> Yes <input type="radio"/> No | Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No |
| Heart Murmur <input type="radio"/> Yes <input type="radio"/> No | Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No | Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No | Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No |
| Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No | Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No | Ulcers <input type="radio"/> Yes <input type="radio"/> No | Convulsions <input type="radio"/> Yes <input type="radio"/> No |
| Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No | G.E.R.D. <input type="radio"/> Yes <input type="radio"/> No | Sjorgens <input type="radio"/> Yes <input type="radio"/> No | Dry Mouth <input type="radio"/> Yes <input type="radio"/> 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: _____

Dr. Austin Smith III
Dr. Nicole Johnston
5120 Corporate Center Ct SE
Lacey, WA 98503
360-352-2400

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so.

We will be calling your home to remind you of appointment date and times. Please indicate to us if you prefer to receive a call at your place of employment.

____ I prefer to be contacted at my place of employment for reminders of appointments

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

Patient or legally authorized individual signature

Date

Printed name if signed on behalf of the patient

Relationship
(parent/legal guardian)

Please read and sign our **FINANCIAL POLICY**.....

- Your investment portion is due at the time of treatment. If you would like an estimate, please ask in advance.
- We accept Cash or Checks, Major Credit Cards and Care Credit.
- Would you like to spread payments over time? Let's talk Care Credit!
- We are happy to submit your dental claims for you.
- While we will strive to help you maximize your insurance benefits, we cannot be held responsible for monitoring your plan limitations and changes.

Treatment and Insurance Authorization:

1. The undersigned hereby authorizes doctor and his auxiliaries to take any diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis and completely treat the patient's dental needs.
2. I also authorize Doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize Doctor to employ such assistance as deemed fit to provide recommended treatment.
3. I understand that it is my responsibility to advise your office of any changes in the information on this form.
4. I hereby authorize my insurance benefits to be paid directly to the dentist. I am financially responsible for any balance due and authorized the dentist to release any information required to complete dental claims. I authorize that my records can be used by the Doctor if he so determines.
5. In consideration of the service rendered to me or my dependants by this dental office, I am obligated to pay said in accordance with its credit terms and policy.
6. I acknowledge that I am financially responsible for all charges whether or not paid by insurance. If it becomes necessary to effect collections of balance due, the undersigned agrees to pay for cost and expenses, including reasonable attorney fees in Thurston County.
7. I certify that I have read, or had read to me, the content of this form and do realize the risks and limitations involved.

Responsible Party:

Date:

Dr. Austin R. Smith

Dr. Nicole M. Johnston

5120 Corporate Center Ct SE

Lacey, WA 98503

360-352-2400

SCHEDULING POLICY

When scheduling appointments we value your time and commitment to your dental care and we appreciate your respect to ours.

We require 24 hour notice for time changes to your appointment. You will be assessed \$100.00 Administrative fee due within 15 days of the cancelation or no show.

Thank you

NAME: _____ DATE: _____