PATIENT REGISTRATION

ID:_____ Chart ID: _____
First Name: _____ Last Name: _____ Middle Initial: _____
Patient is: o Policy Holder Preferred Name: _____
o Responsible Party
***In case of emergency, please contact:**_____ **ph:**_____

Patient Information:
Address: _____ Address 2: _____
City: _____ State/Zip: _____ Pager: _____
Home Phone: _____ Work Phone: _____Ext: _____ Cellular: _____
Sex: o Male o Female Marital Status: o Married o Single o Divorced o Separated o Widowed
Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic: _____
Email: _____ o I would like to receive correspondence via email

Responsible Party (if someone other than patient):
First Name: _____Last Name: _____ Middle Initial: _____
Address: _____ Address 2: _____
City, State, Zip: _____ Pager: _____
Home Phone: _____Work Phone: _____ Ext: _____ Cellular: _____
Birth Date: _____Social Sec: _____ Drivers Lic: _____
O Responsible Party is also a Policy Holder for Patient O Primary Insurance Policy Holder
O Secondary Insurance Policy Holder

Section 2:
Employment Status: O Full Time O Part Time O Retired
Student Status: O Full Time O Part Time
Medicaid ID: _____ Pref. Dentist: _____
Employer ID: _____ Pref. Pharmacy: _____
Carrier ID: _____ Pref. Hygienist: _____

Section 3:

Care Credit: _____
Medical Insurance: _____
Chase Credit: _____

Primary Insurance Information:
Name of Insured: _____ Relationship to Insured: O Self O Spouse O Child O Other
Insured Soc. Sec: _____ Insured Birth Date: _____
Employer: _____ Ins. Company:_____
Address: _____ Address:_____
Address 2: _____ Address 2: _____
City, ST, Zip: _____ City, ST, Zip:_____
Rem. Benefits: _____.00 Rem. Deduct: _____.00

Secondary Insurance Information:
Name of Insured: _____ Relationship to Insured: O Self O Spouse O Child O Other
Insured Soc. Sec: _____ Insured Birth Date: _____
Employer: _____ Ins. Company: _____
Address: _____ Address: _____
Address 2: _____ Address 2: _____
City, ST, Zip: _____ City, ST, Zip: _____
Rem. Benefits: _____.00 Rem. Deduct: _____.00

FINANCIAL OPTIONS

CAPSTONE DENTAL CARE
Dr. John C. Bennett, DMD
Dr. Jennifer T. Dickson, DMD

HOW DID YOU HEAR ABOUT OUR OFFICE?

_____

LIST OTHER FAMILY MEMBERS WHO ARE PATIENTS HERE:

_____

_____

_____

Our goal is to provide you with optimal care based on your individual needs. To assist you in receiving this care, we offer several payment options.

Please indicate below the form of payment you choose: (check one)

- ○ Payment of your portion at each visit (circle one)

We accept:

Cash Check Visa MasterCard American Express Discover

_____/_____

Card # Exp. Date

- ○ Care Credit Payment Plan

I hereby authorize payment directly to Capstone Dental Care of insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the dentists of Capstone Dental Care to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/ medical histories are correct to the best of my knowledge. I grant the right to Capstone Dental Care to release my dental/medical histories and other information about my dental treatment to third party payers and/ or other health professionals.

Service Charge: If I do not pay the entire new balance within 60 days of the appointment date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of 1.5% per month, which is an annual percentage rate of 18%, applied to the last month's balance. In the case of default payment, I promise to pay any legal interest on the balance due, together with any collection costs incurred to effect collection of this amount for future outstanding accounts.

There will be a $30.00 charge for all returned checks.

_____ _____

Signature of Patient/ Responsible Party Date

Thank you for choosing us for your dental needs.

We are pleased to welcome you to our practice. Please take a few minutes to complete this form. If you have any questions we'll be glad to help you. We look forward to working with you in maintaining your dental health. If you have questions about your suggested treatment plan or the available payment options, please ask us. We are here to help you!

Express Prior Consent to Contact Customer By Cell Phone

You agree, in order for us to service your account or to collect monies you may owe CAPSTONE DENTAL CARE and/ or agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/ artificial voice messages and/ or use of automatic dialing device, as applicable.

I/We have read this disclosure and agree that CAPSTONE DENTAL CARE, its employees and/or agents may contact me/us as described above.

- Request Appointments Online
- Confirm Appointments via Email
- Receive Text Message Appointment Reminders
- Submit Patient Satisfaction Surveys
- Refer Your Friends Online

_____ _____

Responsible Party Signature **Date**

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), 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 providers 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 acknowledge that I have received 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 below 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 health care operations. I also understand that you are not required to agree to my request restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

MEDICAL HISTORY

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?	O Yes O No	If yes, please explain: _____
Have you ever been hospitalized or had a major operation?	O Yes O No	If yes, please explain: _____
Have you ever had a serious head or neck injury?	O Yes O No	If yes, please explain: _____
Are you taking any medications, pills, or drugs?	O Yes O No	If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux?	O Yes O No	If yes, please specify: _____
Are you on a special diet?	O Yes O No	
Do you use tobacco?	O Yes O No	
Do you use controlled substances?	O Yes O No	If yes, please specify: _____

Women: Are you
O Pregnant O Trying to get pregnant O Nursing
O Taking oral contraception's

Are you allergic to any of the following?
O Aspirin O Penicillin O Codeine O Acrylic O Metal O Latex O Local Anesthetics
O Other If yes, please explain: _____

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

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

Have you ever had any serious illness not listed above? O Yes O No 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_____