PATIENT REGISTRATION

First Name: _____Last Name: _____Middle Initial: _____

Preferred Name: _____

Patient is : □ Responsible Party □ Policy Holder

Responsible Party: (if someone other than the patient)

First Name: _____Last Name: _____Middle Initial: _____

Address: _____ Address 2: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____Cell Phone: _____

Birth date: _____Social Security #: _____ Drivers Lic#: _____

○ Responsible Party is Policy Holder for Patient ○ Primary Policy Holder ○ Secondary Policy Holder

Patient Information:

Address: _____Address 2: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____Cell Phone: _____

Sex: ○ Female ○ Male Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth date: _____Social Security #: _____ Drivers Lic#: _____

E-mail: _____ □ I would like to receive email correspondences

Primary Insurance Information:

Name of Insured: _____ Relationship to Insured: ○Self ○Spouse ○Child ○ Other

Insured Social Security #: _____ Insured Birth date: _____

Employer: _____ Insurance Company: _____

Address: _____ Address: _____

Address 2: _____Address 2: _____

City, State, Zip: _____City, State, Zip: _____

Secondary Insurance Information:

Name of Insured: _____ Relationship to Insured: ○Self ○Spouse ○Child ○ Other

Insured Social Security #: _____ Insured Birth date: _____

Employer: _____ Insurance Company: _____

Address: _____ Address: _____

Address 2: _____Address 2: _____

City, State, Zip: _____City, State, Zip: _____

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 explain: _____
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
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

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

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 Problem ◯ 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 above? ◯ Yes ◯ No _____

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 _____

LINK DENTAL CARE

Financial Policy

Thank you for choosing us as your dental care provider! The following 2 pages summarize our office financial and appointment policies, which we require you to read and sign prior to becoming a patient.

Regarding Payment

We accept the following forms of payment: Cash, Check (for established patients), Care Credit, Visa, MasterCard, Discover and American Express. Payment for treatment is due at the time the services are rendered. Checks that are returned to our office from your financial institution are subject to a $35 returned-check fee.

Regarding Insurance

If you have dental insurance, we ask that you realize we do not work for an insurance company. Rather, we work 100% for our patients. We feel insurance can be a great benefit for many patients and want you to know we will do everything in our capacity to ensure you get every benefit allotted in your insurance contract. The treatment we recommend and the fees we charge will always be based on your individual needs, not your insurance coverage. At the end of the day, our standard of care, honesty and integrity will be what defines our practice.

Your complete insurance information must be presented before services are rendered. Insurance claims cannot be backdated and most benefits must be verified before your insurance company can be billed. All insurance co-pays and deductibles must be paid at the time of service.

Authorization for Signature on File

I hereby authorize payment directly to Link Dental Care for all insurance benefits otherwise payable to me for dental services rendered. **I understand I am financially responsible for all charges, whether or not paid by insurance, for any and all dental services rendered on my behalf or my dependents.** I authorize Link Dental Care to release all information necessary to secure the payment of benefits and to use my signature below for all insurance submissions.

I have read and understand the above-mentioned policy.

_____ _____

Patient Signature (Parent or Guardian, if minor) Date

LINK DENTAL CARE

Cancellation Policy

Recommended Visits

Your long-term overall health is very important to us and we know it is to you as well. Therefore, we stress that you keep your reserved appointment(s) to help eliminate dental disease and any unnecessary pain.

We understand that illnesses, emergencies, flat tires or bad weather will occur…and sometimes *life just happens*. Our team will always do our best to serve your needs. However, we request that any appointment changes are made as follows:

Office Procedure and Fees (*Read Carefully!*):

- Changing a reserved appointment with at least a 24-hour notice is of no charge or penalty.
    - ♦ Appointment changes are possible only during normal business hours, Monday-Friday.

- Failure to give a proper 24-hour notice will result in a broken appointment and incur a $50 charge.

Definition of a "Broken Appointment":

A broken appointment is when you:

- Change or reschedule an appointment with less than a 24-hour notice (see above).
- Arrive after 15 minutes into your reserved appointment time.
- Do not show up for a reserved appointment.

Confirmation:

- We utilize several methods to confirm you appointments. In the *rare* instance both our automated systems and front office cannot get in contact with you 24 hours before your appointment, we shall have the right to release your reserved time to another patient.

We appreciate your understanding and consideration regarding our appointment procedure and if you have any questions or concerns, never hesitate to ask us.

I have read and understand the above-mentioned policy.

_____ _____

Patient Signature (Parent or Guardian, if minor) Date

PATIENT CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patient:_____

Name:_____

Address:_____

Telephone:_____E-mail:_____

HIPAA requires that we obtain your consent to use and disclose your protected health information for the purposes of carrying out treatment, obtaining payments and carrying on healthcare operations for your care. By signing this consent form, you will have acknowledged that you have read our Notice of Privacy Practices. This notice is available at https://www.linkdentalcare.com/hipaa-notice-of-privacy-practices/. You have the right to revoke this consent by submitting your revocation to us in writing. Any action we took prior to your revocation will not be affected. We may choose to discontinue your treatment if you revoke your consent for us to use and disclose your health information for the reasons stated above.

I, _____, (print your name here) have read the Notice of Privacy Practices and consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature:_____Date:_____

Personal Representative's Name:_____

Relationship to Patient:_____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

REVOCATION OF CONSENT (Not Mandatory)

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.
I understand that any action you took prior to my revocation will not be affected. As a result of my revocation, you may elect to discontinue treating me.

Signature:_____Date:_____