PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

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

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

Emergency Contact

Job Title

Previous Dentist

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: Rem. Deduct:

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: Rem. Deduct:

Time 9:01 AM

Ryan J Hanks DDS Cameron R Stroyan DMD

Date 06/24/20

Woodland Dental Center(Copy)

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 that you may be taking, c

Are you under a physician's care now?	○ Yes ○ No	If yes
Have you ever been hospitalized or had a major operation in the last 5 years?	○ Yes ○ No	If yes
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes
Are you taking any medications, prescribed or over the counter?	○ Yes ○ No	If yes
Are you currently taking blood thinners?	○ 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	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Are you using birth control or HRT

Are you allergic or had any adverse reaction to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Adhesive/tape

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other?	☐	If yes
Do you use controlled substances?	○ Yes ○ No	If yes

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

AIDS/HIV Positive ○ Yes ○ No	Diabetes ○ Yes ○ No	Hepatitis, Jaundice or Liver Disease ○ Yes ○ No	Herpes or HPV ○ Yes ○ No
High Blood Pressure ○ Yes ○ No	Arthritis ○ Yes ○ No	Epilepsy or Seizures ○ Yes ○ No	High Cholesterol ○ Yes ○ No
Shingles ○ Yes ○ No	Artificial Joint ○ Yes ○ No	Hypoglycemia ○ Yes ○ No	Asthma ○ Yes ○ No
Fainting Spells/Dizziness ○ Yes ○ No	Sinus Trouble ○ Yes ○ No	Kidney Problems ○ Yes ○ No	Stomach/Intestinal Disease ○ Yes ○ No
Frequent Headaches ○ Yes ○ No	Stroke ○ Yes ○ No	Bruise Easily ○ Yes ○ No	Low Blood Pressure ○ Yes ○ No
Swelling of Limbs ○ Yes ○ No	Cancer ○ Yes ○ No	Glaucoma ○ Yes ○ No	Thyroid Disease ○ Yes ○ No
Angina ○ Yes ○ No	Heart Attack/Failure ○ Yes ○ No	Osteoporosis ○ Yes ○ No	Tuberculosis ○ Yes ○ No
Cold Sores/Fever Blisters ○ Yes ○ No	Pain in Jaw Joints ○ Yes ○ No	Tumors or Growths ○ Yes ○ No	Congenital Heart Disorder ○ Yes ○ No
Heart Pacemaker ○ Yes ○ No	Heart Trouble/Disease ○ Yes ○ No	Psychiatric Care ○ Yes ○ No	Allergies ○ Yes ○ No
Acid Relux/GERD ○ Yes ○ No	Back Problems ○ Yes ○ No	Abnormal Bleeding ○ Yes ○ No	Respiratory Disease ○ Yes ○ No
Sleep Apnea ○ Yes ○ No	Drug Addiction ○ Yes ○ No		

Have you ever had any serious illness not listed above?	○ 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:_____

Woodland Dental Center

Ryan J. Hanks, DDS • William S. Wiggins, DDS

[Smart Family & Implant Dentistry]

Our Financial Policy

Thank you for choosing Woodland Dental Center! Our primary mission is to deliver the best and most comprehensive dental care available. An important part of our mission is making the cost of optimal care as easy and manageable for you as possible by offering several payment options.

Payment Options:

- Cash, Visa, MasterCard, American Express or Discover
- Convenient monthly payment options[1] from Lending Club or Care Credit patient financing

Please Note

Woodland Dental Center requires payment at the beginning of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

For plans requiring multiple appointments, alternative payment arrangements may be provided. For larger, more comprehensive treatment plans of $2,000 or more, a 20% deposit is required to secure your initial treatment appointment.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.[2]

We charge $40.00 for returned checks.

I acknowledge that payment is due at the time of treatment. I agree that parents, guardians or personal representatives are responsible for all fees and services rendered for treatment of a minor. I accept full financial responsibility for all charges for services or items provided to me or the patient. I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of charges.

If you have any questions, please do not hesitate to ask us.

Patient Name (Please Print) Date

Patient, Parent or Guardian Signature Date

[1]Subject to credit approval

[2]However, if we do not receive payment from your insurance carrier within 60 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

Insurance Assignment and Release

I certify that myself or my dependent(s) is covered by insurance with _____

Name of Insurance Company(ies) And assign directly to Dr. Wiggins/Dr. Hanks all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. I understand all information given by my Insurance Company is only an estimate and never a guarantee.

Dr. Wiggins/Dr. Hanks may use my or my Minor/Child's health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Initial _____

Appointment Policy

Please remember that when you make an appointment, we are reserving at least an hour or more of time in an operatory with an assistant and Doctor or Hygienist. If you cannot make your dental appointment, please call the office **48** hours before your scheduled appointment time. This helps us to fill the time we have reserved specifically for you**. If you cancel within 48hrs of your appointment or fail to show up, $65 will be charged to your account.** (The Friday before a Monday appointment is considered within 24hrs). If you arrive more than 15 minutes late for your dental appointment, we may need to re-schedule you.

Initial _____

Privacy Practices Acknowledgement

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Initial _____

I authorize Woodland Dental Center to mail or leave detailed messages regarding appointments, lab results, financial options/agreements or follow-up information on a voice mail or with any individual answering my phone.

Initial _____

Certification

To the best of my knowledge the information provided on this form is complete and correct. I understand that it is my responsibility to inform Dr. Wiggins/Dr. Hanks/Dr. Stroyan if I or my minor/child ever has a change in health.

Initial _____

Minor/Child Consent

I am the parent, guardian, or personal representative of _____

please Print Name of Minor/Child

And there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental team to perform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by Dr. Hanks or Dr. Wiggins, whether or not I am present when the treatment is rendered.

Initial _____

Please list the names of any individuals that you authorize to have access to your account with us:

_____

Name of authorized person(s) *Relationship to Patient*

_____

***Signature** of Patient or Parent, Guardian or Personal Representative* *Date*

_____

Name of Parent, Guardian or personal Representative (Please Print) *Relationship to Patient*