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

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

Cell Phone: ______

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

Griffin Family Dentistry, P.C.

Medical History (Copy)

Patient Name: Birth Date: Date Created:

Question	Answer		
Are you under a physician's care now? What is his/her name?	Yes No	If yes	
Have you ever been hospitalized or had a major operation? If so, when and what type of 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	
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes	
Are you on a special diet?	Yes No		
Do you use tobacco?	Yes No		
Whom may we thank for referring you to our		omment	

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	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 Problems	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	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:__________

Griffin Family Dentistry

Dr. Robert C. Watson Jr, D.M.D

Cancellation Policy and Confirmation System

Each day in our office, every patient is carefully scheduled in order to allow the necessary time to complete their treatment and provide the quality experience and care we are so proud to give. Unfortunately, we have found, as you probably have, that many offices overbook their schedules expecting that a few patients will not show. We want you to know that *we do not run our office this way.* It is extremely important to us that every patient receive the personal care and attention they deserve. Therefore, appropriate advance notice is required if you absolutely cannot keep your appointment. This time can be allocated to patients in urgent need of treatment. In this way, we can best serve the needs of ALL of our patients.

Bearing this in mind, we ask for 3 business days notice if your appointment must be changed or cancelled. In the event notice is not given , OR if you DO NOT show for your appointment, you will be billed a broken appointment fee, which can be up to the entire fee for the appointment. Our wish is that we never have to charge a patient this fee. Sometimes, patients do not understand the importance of their appointments. This is a critical aspect of our doctor/patient relationship. Simply put, we need you to keep your appointment. And, as always, if you have any questions or concerns about any aspect of your dental care, we are always available and happy to discuss these with you.

Confirmation System

All scheduled appointments need to be confirmed by the patient at least 3 business days ahead of time.

As a courtesy to you, we do the following:

* 2 business days before your appointment, we will text, e-mail or call to confirm your appointment. It is important that you provide us with all of your most current contact information. **Note: It is important for you to respond to one of these means of contact .**

* If we have not heard from you via text or email we will continue to call each day to try and obtain a solid confirmation.

* At any time you would like to opt out of text or email confirmation please notify our office and know you will only receive a phone call reminder.

* We do reserve the right to cancel your appointment and reserve it for another patient if we do not get a confirmation for your appointment.

We appreciate your participation in helping us provide you with the personalized and comfortable care we are proud to offer.

______________________________ ____________________

Patient or Guardian Signature Date

Dr. Robert C. Watson Jr, D.M.D

Payment Policy

* Payment is due as services are rendered. We accept Cash, Check and all major Credit Cards for your convenience.

* Financial arrangements must be made on extensive treatment PRIOR TO the date services are to be rendered.

* We will accept insurance on assignment, but you must pay your deductible and any patient portions due at time of service. Your ESTIMATED portion is due at the time of your visit and you will be billed if your insurance does not pay the estimated amount. We will make every attempt to help you know your benefits but it is the patient's responsibility to know them.

* Our office does NOT guarantee that your insurance will pay. If your insurance company fails to pay your claim within 60 days, you may be billed directly for any applicable amounts. Any balance that is not cleared in 90 days you may accrue a monthly finance charge of 1.5% of the unpaid balance.

* Our office will NOT enter into a dispute with your insurance company over a claim. We file insurance as a courtesy.

* Your are required to sign an "Authorization to Pay Dentist/Physician" form and any other assignment documents required by your insurance company on your first visit. If your company requires their particular form to be filled out, you will need to bring that form with you at each visit. Without the required information completed, we CANNOT file for payment and you will be asked to pay up front for each appointment.

* Verification of benefits is required. If we are unable to verify your benefits, you will be responsible for payment in full at the time services are rendered.

* Accounts not paid in full after 90 days from the time service may be referred to collections or pursued legally in the courts. Any collection fees or court cost in the collection of this debt will be the patient's responsibility.

If you have any questions concerning our office payment policy, please feel free to ask.

I understand and agree that I am absolutely responsible for the balance on my account for professional services rendered. I understand that any insurance benefit is between my insurance company and me and that this dental office does all in it's power to help obtain those benefits.

I have read and understand all of the above.

____________________________________ ____________________

Patient or Guardian Signature **Date**

GRIFFIN FAMILY DENTISTRY – ROBERT C. WATSON, JR., D.M.D.

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient's Name ________________________________D.O.B. ______/_____/_____

- **Authorization for release of Protected Health Information to family members, significant others, and/or friends.**

I authorize the release of any and all health information including diagnosis, dental records, digital x-rays rendered and the release of financial and/or insurance claims information. *This authorization for release of information will remain in effect until terminated in writing.*

This information may be released to:

Name: ____________________________Relationship: _________________________

Name: ____________________________ Relationship: _________________________

Name: ____________________________Relationship: _________________________

(______) Information may only be released to me

- **Authorization for release of Protected Health Information to Dental/Medical Professionals for treatment, payment and healthcare operations**

I authorize the release of my Protected Health Information as necessary for treatment, payment and healthcare operations by electronic transmission, including e-mail, facsimile and by U.S. Mail. It is the policy of Griffin Family Dentistry to protect the electronic transmission of PHI as well as to fulfill our duty to protect the confidentiality and integrity of our patient's PHI as required by law, professional ethics, and accreditation requirements. The information released will be limited to the minimum necessary to meet requestor's needs.

- **Acknowledgement of receipt of Notice of Privacy Practices**

I have read and/or been given a copy of Griffin Family Dentistry's Notice of Privacy Practices, which describe how my health information is used and shared. I understand that Griffin Family Dentistry has the right to change this notice at any time. I understand that I may obtain a current copy by asking Griffin Family Dentistry. My signature below acknowledges that I have read and/or been provided with a copy of the Notice of Privacy Practices.

Patient/Parent/Guardian

Signature:______________________________________Date ____/____/______