# 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

Spouses Name:

Childs Name:

Emergency Num:

Pharm. Num:

Pharmacy Name

Fax Num:

## 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:

Erick K. Perroud, D.D.S., P.C.

**Eaglesoft Medical History -1B**

Patient Name: Birth Date: Date Created:

| | | | |
|---|---|---|---|
| Name and phone of physician(s): | ☐ | If yes | |
| 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 had a surgery or medical condition that requires you take an antibotic pre-medication? | ○ 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 | |
| Are you taking any blood thinners? | ○ 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 | If yes | |
| Do you use tobacco? | ○ Yes ○ No | If yes | |

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

| | | | |
|---|---|---|---|
| Other Allergies? | ☐ | If yes | |
| What was your allergic reaction? | ☐ | 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 | 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 | COPD | ○ Yes ○ No | ADHD / ADD | ○ Yes ○ No | Sleep Apnea | ○ Yes ○ No |
| Parkinson Disease | ○ 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:_____

**DENTAL HISTORY**

**NAME:** _____ **DATE OF BIRTH:** _____

REASON FOR VISIT: _____

WHEN WAS YOUR LAST DENTAL VISIT: _____

HOW OFTEN DID YOU VISIT THE DENTIST: _____

PREVIOUS DENTIST NAME & LOCATION: _____

HAVE YOU HAD A COMPLETE SERIES OF DENTAL X-RAYS TAKEN WHEN & WHERE: _____

_____

HOW OFTEN DO YOU BRUSH YOUR TEETH: _____ HOW OFTEN DO YOU FLOSS: _____

IS YOUR DRINKING WATER FLUORIDATED: _____

DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING: YES NO

ARE YOUR TEETH SENS TO SWEET OR SOUR LIQUIDS/FOODS: YES NO

DO YOU FEEL PAIN TO ANY OF YOUR TEETH: YES NO

DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH: YES NO

HAVE YOU EXPERIENCED ANY OF THE FOLLOWIN PROBLEMS IN YOUR JAW?

CLICKING YES NO

PAIN YES NO

DIFFICULTY OPENING/CLOSING YES NO

DIFFICUTLY CHEWING YES NO

DO YOU CLENCH YOUR TEETH: YES NO

DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY: YES NO HAVE YOU EVER HAD A REACTION TO ANESTHESIA: YES NO

HAVE YOU NOTICED ANY LOOSENING OF YOUR TEETH: YES NO DO YOU BITE YOUR FINGERNAILS OR OTHER THINGS: YES NO

DOES FOOD TEND TO BECOME CAUGHT BETWEEN YOUR TEETH: YES NO

HAVE YOU EVER HAD PERIODONTAL TREATMENT: YES NO

EVER WORN A BITE SPLINT OR OTHER APPLIANCE: YES NO HAVE YOU EVER HAD ORTHODONTIC CARE: YES NO

HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS: YES NO

HAVE YOU EVER HAD ANY PROLONGED BLEEDING FOLLOWING AN EXTRACTION: YES NO

DO YOU WEAR PARTIALS OR DENTURES: YES NO

HAVE YOU EVER RECEIVED ORAL HYGIENE INSTRUCTIONS FOR THE CARE OF YOUR TEETH AND GUMS: YES NO

IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD YOU CHANGE: _____

_____ _____

PATIENT SIGNATURE DATE

## AUTHORIZATION TO DISCLOSE HEALTH INFORMATION TO FAMILY MEMBERS AND FRIENDS

**PATIENT NAME**_____**DATE OF BIRTH**_____

I hereby authorize Erick K. Perroud, DDS, PC to release my patient health information as described below:

| | | Type of Information to Disclose | | | | | Method of Disclosure | |
|---|---|---|---|---|---|---|---|---|
| **Name** | **Relationship** | **Treatment** | **Billing** | **Appointments** | **Financial** | **Insurance** | **By Phone** | **In Person** |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
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| | | | | | | | | |

Protected Health Information ("PHI") may include information/documents regarding dental/medical treatment of the patient including, but not limited to, diagnosis, procedures, treatment plans, appointments and test results; account and billing information including, but not limited to, account balances, payments and payment arrangements, insurance claims status, and third party financing.

I understand that the Health Insurance and Portability and Accountability Act of 1996, and its implementing regulations ("HIPAA") govern the terms of the Authorization. I understand that I have the right to revoke this Authorization, at any time prior to the Practice's compliance with the request set forth herein, provided that the revocation is in writing. I further understand that additional information relating to the exceptions, and the right to revoke and a description of how I may revoke this Authorization is set forth in Erick K. Perroud, DDS, PC's Notice of Privacy Practices. I understand that any revocation must include my name, address, telephone number, date of this Authorization and my signature; and that I should send it to the attention of the "HIPAA Compliance Officer".

I understand that I am not required to sign this Authorization and that Erick K. Perroud, DDS, PC may not condition treatment on my execution of this Authorization.

I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the Recipient listed above and, in that case, will no longer be protected by HIPAA. This authorization expires when I am no longer a patient in this practice or have revoked this authorization.

**(Check One) I DO**_____**I DO NOT**_____**GIVE PERMISSION** to Erick K. Perroud, DDS, PC, to leave information on my answering machine and / or with family members in regard to treatment plans, referrals, test results and / or billing and payment information. HIPAA guidelines allow for basic information regarding appointments (time, date, location) to be left on an answering machine or with family members.

HIPAA regulations authorize the release of PHI for the purpose of treatment, obtaining payment from third party payers, and the day-to-day healthcare operations of Erick K. Perroud, DDS, PC. Other than those releases authorized by HIPAA, PHI will only be released to persons listed on this authorization. If you choose not to authorize any family members or friends for disclosure of PHI, Erick K. Perroud, DDS, PC will not be able to release any information, including appointment or patient billing questions to anyone other than the patient.

_____ _____

**Signature of Patient or Personal Representative (i.e. Guardian)** **Relationship of Personal Representative to Patient**

**Date of Authorization**_____

# PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, hereby acknowledge that I have reviewed and received a copy of this office's *Notice of Privacy* Practices explaining:

*How this office will use and disclose my protected health information.

*My privacy rights with regard to my protected health information.

*This office's obligations concerning the use and disclosure of my protected health information.

I understand that the *Notice of Privacy Practices* may be revised from time to time and that I am entitled to receive a copy of any revised Notice of Privacy Practices upon request.

I also understand that if I have any questions or complaints, I may contact Dr. Erick Perroud at 231-796-6138. Or I may also contact the Secretary of the U. S. Department of Health and Human Services with any concerns regarding our privacy and security policies and procedures. Please contact our office for information on how to contact them.

## PATIENT OR PERSONAL REPRESENTATIVE

Signature: _____ Date: _____

Name: _____

Relationship to Patient: _____

FOR OFFICE USE ONLY:

_____

Dr. Erick Perroud D.D.S., P.C.

203 Fuller Ave.

Big Rapids, MI 49307

231-796-6138 (Office)

231-796-2110 (Fax)

frontdesk@erickperrouddds.com (Email)

07/22/2022

Failed or Missed appointment policy

Our staff has made a promise, professionally and personally, to give you the concern, respect and care that makes our office a comfortable and pleasant place to visit. As such, we consider an appointment made to be an agreement and commitment between our office and our patients, and we rely on our fine patients to abide by that agreement. We have instituted a "failed or missed" appointment policy. This policy allows for some unforeseen emergencies, but on a limited basis. After the first missed appointment, regardless of the circumstances, we reserve the right to charge a service fee of $50.00. If you are not able to keep an appointment, please phone our office within 24 hours and if it is after hours, please leave a message on the answering machine. This will enable us to help you with another appointment and fill your slot with another patient in need.

Pre-med policy

Some of our patients require a pre-med antibiotic before any dental work is performed at our dental office. We will call in a pre-med script with one refill to the pharmacy of your choice. With rising costs, and many patients forgetting to take their pre-med, we have instituted a "pre-med policy". We have pre-med antibiotics in our office just in case our patients forget to take pre-med at home. As a courtesy, we will not charge the first pre-med in office. After the first in office pre-med at no charge, we reserve the right to charge a service fee of $10.00.

If you should have any questions about the above information, please do not hesitate to ask us. We are here to help you.

Sincerely,

Dr. Erick W. Perroud

Erick Perroud, D.D.S., P.C.

Erick Perroud, D.D.S., P.C.
203 Fuller
Big Rapids, MI 49307
231-796-6138

# OUR FINANCIAL POLICY

We are committed to providing you with the best possible care. In order to achieve this goal, we need your assistance and your understanding of our payment policy.

***Payment for service is due at the time service is rendered***. We accept cash, check, credit and debit cards.

We are happy to help you with any insurance questions you may have. We will go over your policy with you, try to maximize your dental benefits, and when necessary request a predetermination of benefits to let you know what your insurer will pay. But please remember your insurer dictates your coverage—we do not. Our fees reflect the quality of service we provide not what insurance companies denote as usual and customary.

As a courtesy to you, all covered services will be billed directly to your insurance carrier(s) by this office. Any co-payment (amount not covered by insurance) is due at the time service is rendered.
You must realize however, that:

*It is the responsibility of the patient, not the dental office, to know what is covered and what is excluded from your dental plan.
*Not all services are a covered benefit in contracts. Some insurance companies arbitrarily select certain services they will not cover.
*Your insurance is a contract between you, your employer and the insurance company.
*We are not a party to that contract.

***We must emphasize that our relationship is with you, not your employer or insurance company.***

If you should have any questions about the above information, please do not hesitate to ask us. We are here to help you.

Sincerely,

Erick Perroud, D.D.S., P.C.