

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

Additional Comments:

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

Eaglesoft Medical History

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?
Have you ever been hospitalized or had a major operation?
Have you ever had a serious head or neck injury?
Are you taking any medications, pills, or drugs?
Do you take, or have you taken, Phen-Fen or Redux?
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?
Are you on a special diet?
Do you use tobacco?
Do you use controlled substances?

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? If yes

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

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

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

Authorization for Release of Information – Compound Release

Name of Patient: _____ Date of Birth: _____

_____ is authorized to release PHI about the above named patient in the following manner and/or to selected persons.

CHECK EACH PERSON/ENTITY APPROVED TO RECEIVE INFORMATION.	CHECK TYPE OF INFORMATION THAT CAN BE GIVEN TO PERSON/ENTITY ON THE LEFT IN THE SAME SECTION.
<input type="checkbox"/> Voice Mail	<input type="checkbox"/> Results of lab tests/x-rays <input type="checkbox"/> Other <u>Appointment reminders</u>
<input type="checkbox"/> Other person (s) (provide name and phone number)	<input type="checkbox"/> Financial <input type="checkbox"/> Medical
<input type="checkbox"/> Email communication-Provide email address* _____ *For email communication to occur, please accept the disclosure below:	<input type="checkbox"/> Financial <input type="checkbox"/> Medical <input type="checkbox"/> Appointment reminders <input type="checkbox"/> Breach notification
<input type="checkbox"/> Text communication – Provide number * _____ *For text communication to occur, accept the disclosure below:	<input type="checkbox"/> Appointment reminder <input type="checkbox"/> Other: _____
<input type="checkbox"/> For email and/or text communication I understand that if information is <i>not</i> sent in an encrypted (secure) manner, there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.	
<input type="checkbox"/> Photo of patient received by patient or legal guardian <input type="checkbox"/> Photo taken by staff (Example: pre/post procedure) <input type="checkbox"/> Other: _____	<input type="checkbox"/> May be posted in office <input type="checkbox"/> May be posted on website <input type="checkbox"/> Other: _____

- Patient's Rights:**
- I have the right to revoke this authorization at any time by contacting this office.
 - I may inspect or copy the protected health information to be disclosed as described in this document.
 - Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
 - Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
 - I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

Signature of Patient or Personal Representative: _____ Date: _____

*Description of Personal Representative's Authority (attach necessary documentation)

Revoked by patient or personal representative on _____.

DATE

How revoked: orally (in person or via phone) in writing (place copy in patient's file)

MARK D. HILL, DDS, PA

727 AYERSVILLE ROAD
P.O. BOX 466
MADISON, NC 27025
TELEPHONE (336) 548-9777
FAX (336) 548-1038

The Notice of Privacy Practice. This notice states in detail that our office does not share any private information with anyone without your permission and gives a complete description of the rights of patients. Our front office has a detailed copy of our notice of privacy practice available for you.

By signing below, I am stating that I have been given the opportunity to read the notice of privacy practice.

Patient:

Date:

Signature of patient (Parent or Guardian if patient is a minor):

MARK D. HILL, DDS, PA

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Thank you for Choosing us as your dental care provider. It is very important to us that we establish the kind of relationship with you that provides the very best of care in the most pleasant environment.

Financial Policy

In order to make financial arrangements for your treatment, we offer several flexible options. We accept cash, checks, Visa, MasterCard, Discover, and American Express as well as Care Credit.

For unaccompanied minors, we ask that financial arrangements be made prior to the day of their appointment.

Dental Insurance

As a courtesy to you we will file your insurance and help you maximize your benefits. We will estimate your insurance coverage and estimate your portion for treatment, which is due on the date of service. As this is an estimate only, you may have an additional balance due or we may issue you a refund after we have received payment from your insurance carrier. It is very important to note that the balance on your account is your responsibility regardless of your carrier's coverage.

Missed Appointments

Please help us serve you and all our patients best by keeping your scheduled appointment. If it is necessary to reschedule an appointment, we require a 24 hour notice so that we may offer the appointment to someone else.

Please note the first visit is an evaluation and does not imply acceptance of patient into the practice. Dr. Hill may need to review previous x-rays and chart.

Signature of Patient (Parent or Guardian if Patient is a minor):
