PATIENT REGISTRATION FORM

4th STREET DENTAL

Today's Date_____

PATIENT REGISTRATION

Patient Name			
Nick Name		Birthdate	Sex M F
Address	City	State	Zip
Student Status FT PT	School	Location	
Home Phone ( )	Cell Phone ( )	Work Phone ( )	
Employer	Business Address	E-mail	
Yrs. Employed	Soc. Sec. No.	Marital Status: S M D W	
Spouse's Name	Spouse's Soc. Sec. No.		
Spouse's Employer	Referred By		
Emergency Contact Name	Relationship	Phone	

PERSON RESPONSIBLE FOR THIS ACCOUNT

Responsible Party's Name		Relationship to Patient
Street Address		Phone
Employer	Years Employed	Soc. Sec. No.
Business Address		Phone

FOR PATIENTS COVERED BY INSURANCE

Subscriber's Name	Employee I.D. #	Birthdate	Soc. Sec. No.
Employer	Business Address		
Insurance Company			Group No.
Insurance Company Address			
Patient's Relation to Subscriber: Self Spouse Dependent		Have You Used Your Dental Insurance This Benefit Year? Yes No	
Are You Covered Under More Than One Dental Plan? Yes No		If Yes, Please Fill Out Next Section	

SECONDARY INSURANCE

Subscriber's Name	Employee I.D. #	Birthdate	Soc. Sec. No.
Employer	Group No.	Insurance Co.	Relationship to Patient
Insurance Company Address			

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient or Responsible Party_____ Date_____

44th Street Dental
3925 W 44th Street • Edina, MN 55424

Payment Policy Acknowledgement

We are committed to deliver the finest, most cost effective dental care available today. Our fees reflect our professional commitment to excellence. In an effort to control fees, we recognize that one of the best methods is to control costs. In order to achieve these goals, we need your assistance and understanding of our payment policy.

For those patients who do not have dental insurance:

1. Payment in full by cash or check is expected for each appointment as service is rendered, unless other prior financial arrangements have been made.
2. For your convenience, we accept Discover, Visa Mastercard or American Express.
3. Alternative financing accounts are gladly accepted. We will offer assistance in filling out an application.

For those patients who do have dental insurance:

1. Our staff understands dental insurance, and will be glad to assist you in obtaining the maximum benefits specified in your contract.
2. We will accept payment directly from the insurance company for the percentage the company will cover.
3. An ESTIMATE will be given of the benefits that the insurance company is expected to pay, and any deductible, co-payments and non-covered fees are expected at the time services are rendered.

It is important that you realize, however that.....

1. Your dental benefit program is a contract between you, your employer, and the insurance company. We are not a party to that contract. This office files your insurance as a courtesy to you.
2. Not all dental services are a covered benefit in all contracts.
3. We will not be responsible for negotiation of any settlements on any disputed insurance claim regarding services rendered by this office. You will be asked to make payment in full when an insurance claim is delayed beyond 45 days of the date of service.

A 1.5%/mo. interest fee will be added to accounts 30 days past due. You will be responsible for any collection agency costs.

Please be aware that any parent bringing a child to our office is legally responsible for payment of all services rendered.

If it is necessary to change your reserved appointment time, we request notification of at least 48 hours in advance of the appointment. Failure to keep an appointment or provide appropriate notification may result in a charge for the appointment time.

We will gladly discuss your proposed dental treatment and answer any questions you might have as to the involvement of your dental benefit program in receiving this care. We appreciate the opportunity to serve you.

_____ _____

Patient or Responsible Party Date

PATIENT MEDICAL HISTORY

44th Street DENTAL

Patient's Name:	Birth Date:
Physician Name:	Physician Phone:
Pharmacy:	Pharmacy Phone:
For Office Use Only: Medical Alerts:	B.P. H.R.
Premedicate: ◯ Yes ◯ No	

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 _____

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? ❑ Nursing?
❑ Taking oral contraceptives?

Are you allergic to any of the following?

❑ Aspirin ❑ Penicillin ❑ Codeine ❑ Acrylic ❑ Metal ❑ Latex ❑ Local Anesthetics

❑ Other If yes, please explain: _____

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

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

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: _____

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 _____

44th Street DENTAL

MEDICAL/DENTAL HEALTH UPDATE

DENTAL INFORMATION

Do you drink sugar pop or diet pop?_____

How much soda pop do you drink each week?_____

How often do you floss?_____

How often do you brush?_____

Date of last teeth cleaning. _____

Date of last dental treatment. _____

Date of last filling. _____

YES	NO		YES	NO	
☐	☐	Have you ever had an upsetting experience in the dental office?			Have you had:
☐	☐	Is it important for you to keep your teeth?	☐	☐	a. Orthodontic treatment (braces)?
☐	☐	Are you dissatisfied with the appearance of your teeth?	☐	☐	b. Oral surgery?
☐	☐	Are you dissatisfied with the function of your teeth?	☐	☐	c. Gum treatment?
☐	☐	Is there anything about having dental treatment that bothers you?	☐	☐	d. Your bite adjusted?
☐	☐	Does food tend to become caught between your teeth?			Do you:
☐	☐	Do your gums bleed while brushing or flossing?	☐	☐	a. Wear a bite plane?
☐	☐	Have you noticed any loosening of teeth?	☐	☐	b. Clench your teeth?
☐	☐	Have you had an injury to your head, neck, or jaw?	☐	☐	c. Bite your lip?
☐	☐	Do you have dryness in your mouth?			Problems of the jaw - Have you noticed:
☐	☐	Are you having dental pain at this time?	☐	☐	a. Clicking of the jaw?
☐	☐	Has anyone in your family had gum disease?	☐	☐	b. Pain (Joint, ear, side of face)?
☐	☐	Do you use fluoride toothpaste?	☐	☐	c. Difficulty in opening or closing?
			☐	☐	d. Difficulty in chewing?

Please explain if you answered "YES" to, or are uncertain about, any of the above items.

_____

_____

_____

_____

_____

To the best of my knowledge, the above information is complete and correct.

Signature:_____ Date:_____

(If Under 18, Parent or Guardian Signature Required)

3925 West 44th Street • Edina, Minnesota 55424

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement*

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

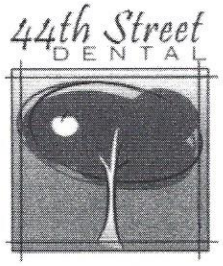
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____



Authorization for Release of Dental Records

Name: _____ Date: _____

I hereby authorize the office below to release all radiographs and dental records related to my care:

Name of Previous Office: _____

Address/City/State/Zip: _____

Phone/FAX: _____

E-mail Address: _____

Please Send To:

44th St Dental
3925 W. 44th St
Edina, MN 55424

OR E-mail us at:
Info@44thstdental.com

I also authorize the release of such records for my dependents listed below:

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Signature: _____ Date of Birth: _____

44th Street Dental
Dr. Steven Veker & Dr. Carl Schneider
3925 W. 44th St Edina, MN 55424
Ph: 952-922-2159 Fax: 952-922-3842