CopperMine Dental Studio

DENTAL REGISTRATION AND HISTORY

Today's Date: _____

1. HOW DID YOU HEAR ABOUT OUR OFFICE?

☐Drove By ☐Ad ☐Insurance ☐Friend _____

☐ Other _____

2. PATIENT INFORMATION

Patient Name _____

Address _____

_____

_____

Patient Social Security # _____

Date of Birth _____Age _____ Sex ☐M ☐F

Mobile Phone_____

Home Phone _____

Work Phone _____

e-mail_____

Employer/School _____

Occupation_____

3. MESSAGES

Our office uses an automated system to remind patients of their appointments.

Which method(s) of confirmation would you prefer? (check all that apply)

☐EMAIL ☐MOBILE TEXT MESSAGE ☐PHONE CALL

4. EMERGENCY CONTACT

Name _____

Relationship _____ Phone_____

5. DESIRED SERVICES (please check all that apply)

☐ HYGIENE/PERIODONTAL ☐ORTHODONTICS

☐ GENERAL DENTISTRY ☐INVISALIGN

☐ COSMETIC DENTISTRY ☐VENEERS

☐ BLEACHING ☐OTHER _____

☐ RESTORATIVE (CROWNS/ DENTURES/IMPLANTS) _____

6. FINANCIAL RESPONSIBILITY

Responsible party (Primary)_____

Primary's Address □ Same as patient

_____

_____

Primary's Phone Number _____

Primary's Date of Birth _____

PRIMARY INSURANCE _____

Employer:_____Group#_____

Insured SSN#_____ID#_____

Patient's Relationship to Primary _____

SECONDARY INSURANCE CO: _____

Secondary Cardholder Name:_____

Secondary's Date of Birth _____

Cardholder Address: _____

_____

Employer: _____ Group#_____

Subscriber SSN: _____ID#_____

Patient Relationship to Secondary: _____

ASSIGNMENT AND RELEASE I, the undersigned, certify that I (or my dependent) have insurance coverage with the above listed insurance carrier(s) and assign directly to CopperMine Dental Studio 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 including those associated with collection efforts of unpaid balances.** I hereby authorize the office to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Signature Date

_____

Print Name

7. SAFETY & PRIVACY

Due to limited space, and in order to protect other patient's privacy under HIPPA regulations, we request that adult patients not be accompanied by anyone in the clinical areas, including patient's young children. Only under special circumstances will permission be granted for someone to accompany an adult patient (i.e. – adult patient that requires a caregiver present)

8. PLEASE LIST MEDICATIONS BEING TAKEN

_____

_____

_____

_____

_____

9. PLEASE LIST ANY ALLERGIES

☐ Latex ☐ Local Anesthetic

☐ Codeine ☐ Penicillin

☐ Nickel

☐ Other _____

10. DENTAL HISTORY

Previous Dentist _____ City/State _____ Date of Last Visit _____

Do you have any concerns about your teeth or oral health? ☐ Yes ☐ No _____

_____

Have you ever had any issues with any dental treatment that you have had in the past? ☐ Yes ☐ No _____

_____

11. MEDICAL HISTORY

Physician's Name _____ City/State _____ Phone Number _____

Have you ever needed to take antibiotics prior to dental treatment? ☐ Yes ☐ No. If yes, why?_____

Have you ever taken Bisphosphonate medication for Osteoporosis(Fosamax, Boniva, Actonel, Didronel, Skelid)?☐Yes ☐No

Please check all that apply:

☐ Artificial Heart Valve

☐ Artificial Joint
What type _____

☐ Cancer
What type _____

☐ Chemotherapy
When _____

☐ Radiation Therapy
When/Where_____

☐ Dental Anxiety/Phobia

☐ Mental/Learning Disabilities

☐ Epilepsy

☐ Heart Attack
When _____

☐ High Blood Pressure

☐ Pacemaker

☐ Stroke
When _____

☐ Shortness of Breath

☐ Acid Reflux/G.I. Problems

☐ Developmental/Growth Problems

☐ Diabetes

☐ HIV Positive

☐ Liver Disease

☐ Kidney Disease

☐ Osteoporosis

WOMEN:
☐ Currently Pregnant
Due date _____

NOTES: _____

_____

_____

_____

_____

_____

_____

(OFFICE USE) ☐ NO MEDICAL CONCERNS Provider Signature_____

12. SIGNATURE

I authorize and give consent to perform dental services including x-rays, intra-oral examinations, and prophylactic services that are Standard of Care in the dental field. Any subsequent treatment needed will be fully explained to me. I certify that the above listed information is correct. I also understand that I am ultimately responsible for any financial obligation for my dental services, and that I am liable for all costs associated to collection not limited to court costs in the event my account is aged over 60 days.

Patient/Parent Signature _____ Date _____

Thank you for completing this form. Please provide photo ID and Insurance Cards to staff member

To Our Patients

We are pleased that you have chosen CopperMine Dental Studio for your dental care. Our goal is to provide you with the best available dental care, as well as allow our patients with dental insurance to maximize their benefits.

Dental insurance is a benefit provided to you through your employer. As a courtesy, we are happy to file your insurance at no cost to you. Please be aware that your insurance coverage is an agreement between you (or your employer) and your insurance company. **You are ultimately responsible for all charges incurred in our office.** We will do our best to help you maximize your dental benefits and minimize any conflict.

We encourage you to verify your co-payment and deductibles with your dental insurance company. If you have any questions regarding your insurance coverage please contact your insurance company directly (or the Human Resource department of your employer).

Following creation of a treatment plan we will review all costs and provide you with an estimate of insurance benefit. Due to the expansive number of insurance plans and the many rule and regulations that they use to determine coverage **we cannot guarantee that our estimates are 100%.** At your request, we can submit for a Pre-determination of Benefits from your insurance company, although this can delay treatment up to one month.

All estimated co-payments are due at the time service is provided. If there is a **discrepancy between the estimated co-payment paid and the actual benefits paid a statement (or refund) will be sent to you. Payment of any outstanding debt is due within 15 days of the statement. There is a $35.00 fee for returned checks.**

Please give us a 48-hour notice to cancel an appointment. **There will be a fee of $40.00 for missed appointments.**

We look forward to serving all your dental needs and will do all we can to help you maximize your dental coverage.

Thank you
CopperMine Dental Studio

Print Patient Name Date

Patient signature (or parent if patient is a minor)

CopperMine Dental Studio
NOTICE OF PRIVACY PRACTICES

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 Notices.
(Please Print Name)

_____
(Signature) (Date)

I agree to allow the following person(s) to discuss clinical and financial issues with the Doctors and Staff of CopperMine Dental Studio:

_____ _____
(Name) (Name)

_____ _____
(Relationship to Patient) (Relationship to Patient)

FOR OFFICIAL 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

___ Communication barriers prohibited obtainment of the acknowledgement

___ An emergency situation prevented us from obtaining acknowledgement

___ Other (Please specify):

_____