Welcome to Elkins Dental

Patient Registration

Date_____

Patient Information

First Name (Legal):_____Middle Initial: _____ Last Name: _____
Preferred Name: _____ Referred by: _____
Address: _____ Mailing Address: _____
City, State, Zip: _____
Home phone: _____ Work: _____ Ext: _____ Cell: _____
□ I would like to receive correspondence via email. Email Address: _____
Male____ Female____ Marital Status: Married____ Single ____ Divorced ___ Widowed _____
Birth Date: _____ Age: _____ Social Sec: ____-____-_____ DL Number: _____

Employment Status: Full Time _____ Part Time: _____ Retired: _____
Student Statue: Full Time _____ Part Time _____
Employer: _____Employer Phone: _____
Spouses Legal Name: _____ Social Sec: _____-_____-_____
Spouses Employer: _____ Employer Phone: _____
Emergency Contact: _____ Phone: _____

Parent or Legal Guardian Information

First Name (Legal):_____Middle Initial: _____ Last Name: _____
Preferred Name: _____ Referred by: _____
Address: _____ Mailing Address: _____
City, State, Zip: _____ Email Address: _____
Home phone: _____ Work: _____ Ext: _____ Cell: _____
Male____ Female____ Marital Status: Married____ Single ____ Divorced ____ Widowed ____
Birth Date: _____ Age: _____ Social Sec: _____-_____-_____ DL Number: _____

Employment Status: Full Time _____ Part Time: _____ Retired: _____
Student Statue: Full Time _____ Part Time _____
Employer: _____ Employer Phone: _____
Spouses Legal Name: _____ Social Sec: _____-_____-_____
Spouses Employer: _____ Employer Phone: _____

Primary Insurance Information

Name of Policy Holder: _____ Relationship to Patient: _____
Policy Holder ID # or Social Sec: _____-_____-_____ Insured Birth Date: _____
Employer: _____ Insurance Company Name: _____

Secondary Insurance Information

Name of Policy Holder: _____ Relationship to Patient: _____
Policy Holder ID # or Social Sec: _____-_____-_____ Insured Birth Date: _____
Employer: _____ Insurance Company Name: _____

Financial Agreement

Thank you for choosing Elkins Dental. We are committed to excellence, and we feel that you deserve nothing less when it comes to your dental health. We use the best materials and techniques available in order to provide you with the quality you have come to expect from us.

We believe that our relationship with you, as with all relationships, needs to have open and clear communication. We will try to communicate all of your dental needs and estimate your financial information as soon as it becomes evident. We want you to be as informed as possible to help you in your decisions concerning your dental health.

Payment is expected at the time treatment is performed. As a courtesy to our patients with dental benefits we will submit your claims to your insurance company. Any portion that is not expected to be covered by these benefits is the **responsibility of the patient and is due at the time services are rendered.** This amount will include deductibles and co-payments. If benefit amounts are less than expected, you will be billed for the differences and payment is due within 90 days.

Dental benefits are contracts between the policy holder and the insurance company. We will make every effort to assist you with any benefit questions, however we suggest that you be aware of individual policy clauses, such as waiting periods and of what benefits you have available. Ultimately, you are responsible for any unpaid balance.

We want you to be comfortable with our team. If you ever have any questions about your dental treatment, financial or insurance questions, or any concerns at all, we ask that you notify us as soon as possible. We will be glad to clarify any uncertainties that may arise.

Marital status is not a consideration under any circumstances. Decreed custody or lack thereof, does not alter any financial responsibility. The parent accompanying the child/minor on the day of service will be considered the responsible party. We will gladly provide you with copies of statements, which you may need to provide to the other parent for reimbursement.

There is a **$35.00 charge** for all returned checks. If a check is returned and not paid within 7 days of return date, legal action may be taken for collection. Any costs associated with collection of returned checks will be assumed by you.

In the event that your account becomes delinquent, you will be responsible for all collection fees, attorney fees, and court costs.

For your convenience we do accept many forms of payment including cash, check, Visa, Mastercard, American Express, and we also offer third party financing, which includes interest free programs. Ask our staff for details.

Broken Appointment Policy

We understand how valuable your time is, so we make every effort to remain on time. We do not double book our reservations. We feel that you deserve our complete and focused attention so that we may provide the best care possible. Your scheduled appointment is reserved exclusively for you. We have a 24 hour cancellation policy in order to provide you with this personalized attention. We understand that circumstances may arise that require a reservation to be rescheduled. If sufficient notice is not given, your account will automatically be charged a **$50.00 missed reservation fee.** We ask that you make every effort to keep your reserved time.

Notice of Privacy Practices

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

Electronic Communication

I agree that Elkins Dental may communicate with me electronically at the e-mail address/phone number provided.

Photo Release

I hereby authorize Elkins Dental to take photographs, slides, and/or videos of me. I understand that my name and/or photos may be used for social media announcements of winners and/or for any marketing purposes. I do not expect compensation, financial or otherwise, for the use of these photographs.

Patient's Printed Name

_____Date_____

Patient, Parent/ Legal Guardian Signature

_____Date _____

Time 12:26 PM | Elkins Dental | Date 6/18/2019

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?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major 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	
Do you use controlled substances?	◯ 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? ☐ 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 above? ◯ 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:_____