

TIME 02:20 PM

DATE 11/15/201

**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.

<p>Section 2</p> <p>Employment Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired</p> <p>Student Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time</p> <p>Medicaid ID: _____ Prof. Dentist: _____</p> <p>Employer ID: _____ Prof. Pharmacy: _____</p> <p>Carrier ID: _____ Prof. Hyg: _____</p>	<p>Section 3</p> <p>Emergency Contact _____</p> <p>Job Title _____</p> <p>Previous Dentist _____</p>
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Primary Insurance Information

Name of Insured: \_\_\_\_\_ Relationship to Insured:  Self  Spouse  Child  Other

Insured Soc. Sec: \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_

<p>Employer: _____</p> <p>Address: _____</p> <p>Address 2: _____</p> <p>City, State, Zip: _____</p> <p>Rem. Benefits: _____</p>	<p>Ins. Company: _____</p> <p>Address: _____</p> <p>Address 2: _____</p> <p>City, State, Zip: _____</p> <p>Rem. Deduct: _____</p>
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Secondary Insurance Information

Name of Insured: \_\_\_\_\_ Relationship to Insured:  Self  Spouse  Child  Other

Insured Soc. Sec: \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_

<p>Employer: _____</p> <p>Address: _____</p> <p>Address 2: _____</p> <p>City, State, Zip: _____</p> <p>Rem. Benefits: _____</p>	<p>Ins. Company: _____</p> <p>Address: _____</p> <p>Address 2: _____</p> <p>City, State, Zip: _____</p> <p>Rem. Deduct: _____</p>
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Woodland Dental Center(Copy)

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

Are you under a physician's care now?  Yes  No If yes

Have you ever been hospitalized or had a major operation in the last 5 years?  Yes  No If yes

Have you ever had a serious head or neck injury?  Yes  No If yes

Are you taking any medications, prescribed or over the counter?  Yes  No If yes

Are you currently taking blood thinners?  Yes  No If yes

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?  Yes  No If yes

Do you use tobacco?  Yes  No

Women: Are you...

Pregnant/Trying to get pregnant?  Nursing?  Are you using birth control or HRT

Are you allergic or had any adverse reaction to any of the following?

Aspirin  Penicillin  Codeine  Adhesive/tape  
 Metal  Latex  Sulfa Drugs  Local Anesthetics

Other?  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 <input type="radio"/> Yes <input type="radio"/> No	Diabetes <input type="radio"/> Yes <input type="radio"/> No	Hepatitis, Jaundice or Liver Disease <input type="radio"/> Yes <input type="radio"/> No	Herpes or HPV <input type="radio"/> Yes <input type="radio"/> No
High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Arthritis <input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No	High Cholesterol <input type="radio"/> Yes <input type="radio"/> No
Shingles <input type="radio"/> Yes <input type="radio"/> No	Artificial Joint <input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No	Asthma <input type="radio"/> Yes <input type="radio"/> No
Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No	Kidney Problems <input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No
Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No	Stroke <input type="radio"/> Yes <input type="radio"/> No	Bruise Easily <input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No
Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No	Cancer <input type="radio"/> Yes <input type="radio"/> No	Glaucoma <input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No
Angina <input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No	Osteoporosis <input type="radio"/> Yes <input type="radio"/> No	Tuberculosis <input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No	Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No
Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No	Allergies <input type="radio"/> Yes <input type="radio"/> No
Acid Relux/GERD <input type="radio"/> Yes <input type="radio"/> No	Back Problems <input type="radio"/> Yes <input type="radio"/> No	Abnormal Bleeding <input type="radio"/> Yes <input type="radio"/> No	Respiratory Disease <input type="radio"/> Yes <input type="radio"/> No
Sleep Apnea <input type="radio"/> Yes <input type="radio"/> No	Drug Addiction <input type="radio"/> Yes <input type="radio"/> 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: \_\_\_\_\_

I certify that myself or my dependent(s) is covered by insurance with \_\_\_\_\_  
*Name of Insurance Company(ies)*

And assign directly to Dr. Wiggins/Dr. Hanks 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. I authorize the use of my signature on all insurance submissions. I understand all information given by my Insurance Company is only an estimate and never a guarantee.

Dr. Wiggins/Dr. Hanks may use my or my Minor/Child's health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Initial \_\_\_\_\_

### Appointment Policy

Please remember that when you make an appointment, we are reserving at least an hour or more of time in an operatory with an assistant and Doctor or Hygienist. If you cannot make your dental appointment, please call the office **48** hours before your scheduled appointment time. This helps us to fill the time we have reserved specifically for you. **If you cancel within 48hrs of your appointment or fail to show up, \$65 will be charged to your account.** (The Friday before a Monday appointment is considered within 24hrs). If you arrive more than 15 minutes late for your dental appointment, we may need to re-schedule you.

Initial \_\_\_\_\_

### Privacy Practices Acknowledgement

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Initial \_\_\_\_\_

I authorize Woodland Dental Center to mail or leave detailed messages regarding appointments, lab results, financial options/agreements or follow-up information on a voice mail or with any individual answering my phone.

Initial \_\_\_\_\_

### Certification

To the best of my knowledge the information provided on this form is complete and correct. I understand that it is my responsibility to inform Dr. Wiggins/Dr. Hanks/Dr. Stroyan if I or my minor/child ever has a change in health.

Initial \_\_\_\_\_

### Minor/Child Consent

I am the parent, guardian, or personal representative of \_\_\_\_\_  
*please Print Name of Minor/Child*

And there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental team to perform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by Dr. Hanks or Dr. Wiggins, whether or not I am present when the treatment is rendered.

Initial \_\_\_\_\_

**Please list the names of any individuals that you authorize to have access to your account with us:**

\_\_\_\_\_  
*Name of authorized person(s)* *Relationship to Patient*

\_\_\_\_\_  
*Signature of Patient or Parent, Guardian or Personal Representative* *Date*

\_\_\_\_\_  
*Name of Parent, Guardian or personal Representative (Please Print)* *Relationship to Patient* *Name of*



## Woodland Dental Center

Ryan J. Hanks, DDS • William S. Wiggins, DDS

[Smart Family & Implant Dentistry]

### Our Financial Policy

Thank you for choosing Woodland Dental Center! Our primary mission is to deliver the best and most comprehensive dental care available. An important part of our mission is making the cost of optimal care as easy and manageable for you as possible by offering several payment options.

### Payment Options:

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- Cash, Visa, MasterCard, American Express or Discover  
We also offer a 5% courtesy discount to patients who pay for their treatment with cash prior to completion of care who don't have dental insurance.
- Convenient monthly payment options<sup>1</sup> from Lending Club or Care Credit patient financing

### Please Note

Woodland Dental Center requires payment at the beginning of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

For plans requiring multiple appointments, alternative payment arrangements may be provided. For larger, more comprehensive treatment plans of \$2,000 or more, a 20% deposit is required to secure your initial treatment appointment.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.<sup>2</sup>

We charge \$30.00 for returned checks.

I acknowledge that **payment is due at the time of treatment**. I agree that parents, guardians or personal representatives are responsible for all fees and services rendered for treatment of a minor. I accept full financial responsibility for all charges for services or items provided to me or the patient. I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of charges.

**If you have any questions, please do not hesitate to ask us.**

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Patient Name (Please Print)

Date

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Patient, Parent or Guardian Signature

Date

<sup>1</sup>Subject to credit approval

<sup>2</sup>However, if we do not receive payment from your insurance carrier within 60 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.