PATIENT REGISTRATION

PLEASE FILL OUT THIS FORM COMPLETELY

Patient Information:

First Name: _____ Last Name: _____ Middle Initial: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Social Security Number: _____ Driver's License: _____

Sex: _____ *Male* _____ *Female* _____ *Prefer not to answer*

Marital Status: _____ *Single* _____ *Married* _____ *Separated* _____ *Widowed* _____ *Other*

Employment Status: _____ *Full Time* _____ *Part Time* _____ *Retired* _____ *N/A*

Student Status: _____ *Full Time* _____ *Part Time* _____ *N/A*

Phone: _____ Alternate Phone: _____ Is Texting Okay: _____

Email: _____ How do you prefer we contact you: _____

Preferred Pharmacy: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: _____

Primary Insurance Information:

Name of Policy Holder: _____ Relationship to Policy Holder: _____ Self _____ Spouse _____ Child _____ Other

Policy Holders Soc. Sec.: _____ Policy Holder's Birth Date: _____

Group Number: _____ Member ID Number: _____

Employer: _____

Address: _____

City, State, Zip: _____

Phone Number: _____

Insurance Company: _____

Address: _____

City, State, Zip: _____

Phone Number: _____

Secondary Insurance Information:

Name of Policy Holder: _____ Relationship to Policy Holder: _____ Self _____ Spouse _____ Child _____ Other

Policy Holders Soc. Sec.: _____ Policy Holder's Birth Date: _____

Group Number: _____ Member ID Number: _____

Employer: _____

Address: _____

City, State, Zip: _____

Phone Number: _____

Insurance Company: _____

Address: _____

City, State, Zip: _____

Phone Number: _____

Janssen Dental Clinic

Eaglesoft Medical History 2022

Patient Name: Birth Date: Date Created:

It is important that you provide a complete and accurate medical history to enable us to provide you with the best dental care possible.

Primary Care Provider Information (Name and Phone Number)	☐	If yes	
Specialty Care Provider(s) Information (Name and Phone Number)	☐	If yes	
Have you ever been hospitalized or had any surgeries (minor or major)? List any/all surgeries you have had.	◯ Yes ◯ No	If yes	
Have you ever had a head or neck injury (minor or major)? If yes, please list.	◯ Yes ◯ No	If yes	
Have you ever been treated for TMJ issues? If yes, please list.	◯ Yes ◯ No	If yes	
Have you ever taken any medications to address osteoporosis? If yes, please list.	◯ Yes ◯ No	If yes	
Are you on a special diet?	◯ Yes ◯ No	If yes	
Do you use tobacco or vape? If yes, please list type and frequency.	◯ Yes ◯ No	If yes	
Any recreational drug use (or history)? If yes, please list type and frequency.	◯ Yes ◯ No	If yes	

Medications/Supplements:

Please note any and all allergies.

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Chemical Sensitivity
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Food, Seasonal and Other Allergies ☐ If yes

Please check box(s) if you have or have had, any of the following?

☐ ADD/ADHD	☐ COPD	☐ Heart Trouble/Disease	☐ Parathyroid Disease
☐ AIDS/HIV Positive	☐ Cortisone Medicine	☐ Hemophilia	☐ Pregnant/Nursing
☐ Alcoholism	☐ Crohn's Disease	☐ Hepatitis A	☐ Psychiatric Care
☐ Alzheimer's Disease	☐ Depression	☐ Hepatitis B or C	☐ Radiation Treatments
☐ Anemia	☐ Diabetes	☐ High Blood Pressure	☐ Recent Weight Loss
☐ Anxiety	☐ Drug Addiction	☐ High Cholesterol	☐ Renal Dialysis
☐ Artificial Heart Valve	☐ Easily Winded	☐ Hives/Rash	☐ Rheumatism
☐ Artificial Joint	☐ Eating Disorder	☐ Hypoglycemia	☐ Shingles
☐ Arthritis/Gout	☐ Emphysema	☐ Irregular Heartbeat	☐ Sinus Trouble
☐ Asthma	☐ Epilepsy/Seizures	☐ Irritable Bowel Syndrome	☐ Sleep Apnea
☐ Autism	☐ Excessive Bleeding	☐ Kidney Problems	☐ Stomach/Intestinal Disease
☐ Bipolar	☐ Fainting Spells/Dizziness	☐ Kidney Stone/s	☐ Stroke
☐ Blood Transfusion	☐ Frequent Cough	☐ Leukemia	☐ Swelling of Limbs
☐ Breathing Problems	☐ Frequent Diarrhea	☐ Liver Disease	☐ Thyroid Disease
☐ Bruise Easily	☐ Frequent Headaches	☐ Low Blood Pressure	☐ Tonsilitis
☐ Cancer	☐ Gall Bladder	☐ Lung Disease	☐ Tuberculosis
☐ Chemotherapy	☐ Glaucoma	☐ Migraines	☐ Tumors/Growths
☐ Chest Pains	☐ Hay Fever	☐ Mitral Valve Prolapse	☐ Ulcers
☐ Cold Sores/Fever Blisters	☐ Heart Attack/Failure	☐ Osteoporosis	☐ Venereal Disease
☐ Congenital Heart Disorder	☐ Heart Murmur	☐ Pain in Jaw Joints	☐ Yeast Infection (Chronic)
☐ Convulsions	☐ Heart Pacemaker	☐ Pancreatitis	☐ Yellow Jaundice

Do you have or have had any illnesses 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:_____

Cancellation Policy

We strive to provide the best care for our patients, that is why we require a 48-hour notice for any appointment cancellations. Weekends are not included in the 48-hour window as we cannot take your call and fill your appointment time. Failing appointments or cancelling inside the 48-hour window deprives other patients from timely care and negatively impacts our employees.

Excessive appointment failures or cancellations without enough notice can result in any of the following:

Prepayment for all appointments
Same day appointments only
Dismissal from practice

Please respect our time as we will do everything possible to respect yours as well. Thank you for understanding.

Financial Policy

We are a fee for service office. We are not in network with any insurance companies to be better able to serve our patients needs. We are committed to providing you with the highest quality dental care using only the best materials and technology available. We are also committed to providing you with up-to-date information and educational tools so that you may fully participate in maintaining optimum oral systemic health.

ALL CHARGES YOU INCUR ARE YOUR RESPONSIBILITY REGARDLESS OF YOUR INSURANCE COVERAGE.

We must emphasize that as your dental care provider, our relationship is with you, not your insurance company. Your insurance policy is a contract between you, your employer, and the insurance company. Our office is not a party to that contract. If payment from your insurance company is not received within 60 days from the date of service, you will be expected to pay the balance in full.

As a courtesy to you, we will submit to your dental insurance on your behalf. In order for our office to file your insurance claim, you must provide us with your correct insurance information and of any changes thereafter.

Full treatment payment is expected before or at the time service is provided unless otherwise arranged. Sedation appointments will require payment prior to appointment. Our office does accept cash, check and major credit cards. Outside financing is available through CareCredit, upon approval.

Please see our financial agreement form for all payment options.

Returned checks are subject to a $35.00 fee.
Balances older than 30 days are subject to a billing charge of $5.
Balances older than 60 days are subject to finance charges at the rate of 1.5% per month (18% annually).
Balances older than 90 days may be turned over for collections or small claims court.

If you have any questions regarding our financial policy, please ask.

_____ _____

Signature Date

Janssen Dental Clinic HIPAA Privacy Authorization Form

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices.

We routinely use your health information inside our office without any special permission. If we need to disclose your health information outside of our office for any of the following reasons, we will not ask you for special written permission.

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for are: prescribing medications and/or faxing them to be filled, referring you to another doctor or clinic for other health care or services, getting copies of your health information from another professional that you may have seen before us, scheduling an appointment, and confirming your appointment. Unless you tell us otherwise, we will leave you a reminder message on your answering machine or with someone who answers your phone if you are not home

Any minor must be accompanied by an adult. The adult that accompanies the minor for their first appointment will be the responsible party until the minor is 18 or a revoke request is processed by either written or electronic submission.

I authorize the professional office of Janssen Dental Clinic to release health information and billing information to:

To whom may the information be released (If no one is authorized on the account, keep the space blank):

Detailed description of the information to be released (if modified from above):

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoke. Send this note to the office contact listed at the top of this form.

By law, we must abide by the terms of this Notice of Privacy Practices. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new Private Practices will apply to your health information that we already have as well as to such information that we may generate in the future.

I hereby authorize the release of all medical information necessary to process my claims and I authorize release of this same information, when necessary, to other providers rendering medical/ dental care, as well as to labs that need my information to make a diagnosis or fabricate an appliance necessary for my treatment.

I assign all medical and surgical benefits, including major medical benefits to which I am entitled, to Janssen Dental Clinic. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered a valid as the original.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Patient Name: _____

Patient Signature: _____ Date: _____
(or representative)

If you are signing as a personal representative of the patient, describe your relationship to the patient.

Relationship to Patient: _____