Downtown Dental Patient Registration

PATIENT INFORMATION (CONFIDENTIAL)

Patient Full Name: _____ Nickname: _____

Date of Birth: _____ **Gender**: ☐ Male ☐ Female **Social Security #**: _____

Responsible Party: ☐ Self ☐ Other: _____

CONTACT INFORMATION

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Ph: _____ **Cell Ph:** _____ **Work Ph:** _____

Email: _____

PREFERENCES

Dentist: ☐ Dr. Peter Zehren ☐ Dr. Ryan Gerts ☐ Dr. Kyle Coon **Hygienist**: _____

Pharmacy: _____

DENTAL RECORDS

Previous Dentist: _____ **City:** _____ **State:** _____

OTHER / ADDITIONAL IDENTIFIERS

Emergency Contact & Relationship: _____ Emergency Contact Phone #: _____

Who can we thank for referring you to our practice? _____

INSURANCE INFORMATION

Do you have **Primary** Dental Insurance? ☐ Yes ☐ No

Group # & Name: _____

Member ID: _____

Insurance Company Name: _____

Insurance Company Phone #: _____

Employer Name: _____

Subscriber Name: _____

Relationship to Patient: _____

Subscriber Date of Birth: _____

Subscriber Social Security #: _____

Do you have **Secondary** Dental Insurance? ☐ Yes ☐ No

Group # & Name: _____

Member ID: _____

Insurance Company Name: _____

Insurance Company Phone #: _____

Employer Name: _____

Subscriber Name: _____

Relationship to Patient: _____

Subscriber Date of Birth: _____

Subscriber Social Security #: _____

Health History

1. Do you have any of the following diseases or problems:

   ☐ Active Tuberculosis
   ☐ Persistent cough greater than a 3-week duration
   ☐ Cough that produces blood
   ☐ Been exposed to anyone with tuberculosis

2. Are you now under the care of a physician?

   Physicians Name: _____ Clinic Name & Location: _____

3. Are you in good health? ☐ Yes ☐ No
4. Has there been any change in your general health within the past year? ☐ Yes ☐ No
   - If yes, what condition is being treated? _____
5. Date of last physical exam: _____
6. Have you had a serious illness, operation or been hospitalized in the past 5 years? ☐ Yes ☐ No
   - If yes, what was the illness or problem? _____
7. Are you taking or have you recently taken any prescription or over the counter medicine(s)? If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:

   _____

   _____

   _____

8. Do you wear contact lenses? ☐ Yes ☐ No
9. Joint Replacement: Have you had any orthopedic total joint (hip, knee, elbow, finger) replacement? ☐ Yes ☐ No
   - If yes, date: _____
   - If yes, have you had any complications? _____
10. Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate(Actonel®) for osteoporosis or Paget's disease? ☐ Yes ☐ No
11. Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?
    - If yes, date treatment began: _____
12. Do you use controlled substances (drugs)? ☐ Yes ☐ No
13. Do you use tobacco (smoking, snuff, chew, bidis)? If yes, which one: _____
    - If so, are you interested in stopping? (circle one) VERY / SOMEWHAT / NOT INTERESTED
14. Do you drink alcoholic beverages? ☐ Yes ☐ No
    - If yes, how much alcohol did you drink in the last 24 hours? _____
    - If yes, how much do you typically drink in a week? _____

WOMEN ONLY:

1. Are you pregnant? ☐ Yes ☐ No
2. If so, number of weeks: _____
3. Are you taking birth control pills? ☐ Yes ☐ No
4. Are you nursing? ☐ Yes ☐ No

Health History (continued)

Allergies, are you allergic to or have you had any reaction to:

☐ Local anesthetics
☐ Aspirin
☐ Penicillin or other antibiotics
☐ Barbiturates
☐ Sedatives
☐ Sleeping pills
☐ Sulfa drugs
☐ Codeine or other narcotics
☐ Metals
☐ Latex (rubber)
☐ Iodine
☐ Hay fever/seasonal
☐ Animals
☐ Food
☐ Other

If other, please specify: _____

Congenital Heart Disease (CHD) - Please indicate if you have had any of the following:

☐ Artificial (prosthetic) heart valve
☐ Previous infective endocarditis
☐ Damaged valves in transplanted heart
☐ Congenital heart disease (CHD)
☐ Unrepaired, cyanotic CHD
☐ Repaired (completely) in the last 6 months
☐ Repaired CHD with residual defects

Additional comments: _____

Other Conditions - Please indicate if you have had any of the following:

☐ Cardiovascular disease
☐ Angina
☐ Arteriosclerosis
☐ Congestive heart failure
☐ Damaged heart valves
☐ Heart attack
☐ Heart murmur
☐ Low blood pressure
☐ High blood pressure
☐ Other congenital heart defects
☐ Mitral valve prolapse
☐ Pacemaker
☐ Rheumatic fever
☐ Rheumatic heart disease
☐ Abnormal bleeding
☐ Anemia
☐ Blood transfusion – If yes, date: _____
☐ Hemophilia
☐ AIDS or HIV
☐ Arthritis
☐ Autoimmune disease
☐ Rheumatoid arthritis
☐ Systemic lupus erythematosus
☐ Asthma
☐ Bronchitis
☐ Emphysema
☐ Sinus trouble
☐ Tuberculosis
☐ Cancer
☐ Chemotherapy
☐ Radiation Treatment
☐ Chest pain upon exertion
☐ Chronic pain
☐ Diabetes: ☐ Type 1 ☐ Type 2
☐ Eating disorder
☐ Malnutrition
☐ Gastrointestinal disease
☐ G.E. Reflux/persistent heartburn
☐ Thyroid problems
☐ Stroke
☐ Glaucoma
☐ Hepatitis, jaundice or liver disease
☐ Epilepsy
☐ Fainting spells or seizures
☐ Neurological disorders – If yes, please specify: _____
☐ Sleep disorder
☐ Mental health disorders – If yes, please specify: _____
☐ Recurrent infections – If yes, type of infection: _____
☐ Kidney problems
☐ Night sweats
☐ Osteoporosis
☐ Persistent swollen glands in neck
☐ Severe headaches/migraines
☐ Severe or rapid weight loss
☐ Sexually transmitted disease
☐ Excessive urination
☐ Taking a Blood Thinner

Health History (continued)

Premedication

1. Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?

   ☐ Yes ☐ No

2. Name of physician or dentist making recommendation (include phone number):

   _____

3. Do you have any disease, condition, or problem not listed above that you think we should know about?

   Please explain: _____

   _____

   _____

Records Release Information

I, the patient, give permission for any correspondence such as x-rays, clinical notes, referrals, etc. to be sent via email or mail. I also authorize the Zehren Dental, Winona Dental Implant Center, Gerts Dental, and Downtown Dental staff to discuss my dental records, treatment plans, payment plans, and treatment rendered with the following:

☐ Spouse: _____

☐ Family: _____

☐ Guardian: _____

☐ Referring Specialist: _____

☐ Veterans Affairs: _____

☐ Others not listed above: _____

Cancellation Policy

Your appointment time has been reserved exclusively for you, and any changes affect many other patients, the doctors schedule, and staffing. When it is necessary to change an appointment, we require a minimum of a 24-hour notice, making it possible for another patient to use that scheduled time. We understand unforeseen circumstances arise, and we will take your situation into consideration. We realize accidents happen, family members get sick, and emergencies occur. We will do our best to accommodate these rare occasions with grace, but please remember we track these occurrences to prevent abuse of the policy. Thank you for your cooperation and understanding in this matter. The policy exists to maintain our service expectations and to respect all of our patients' time and our staffs' time. We appreciate your help in continuing to provide you with the best possible care!

OFFICE FINANCIAL POLICY

We would like our patients to be informed of our office financial policy. Zehren Dental, Winona Dental Implant Center, Gerts Dental, and Downtown Dental are committed to providing you with the best possible care. We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between the provider and patient. If you have dental insurance, our goal is to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our financial policy. We also want you to understand that there are no guarantees in medicine and dentistry.

Payment for services is due in full at the time services are rendered, unless payment arrangements have been approved in advance by our staff. If you have insurance, we will gladly submit your claim, but your estimated co-pay is due on the day of service. We accept cash, personal checks, Visa, MasterCard, Discover, American Express, Apple Pay, & Google Pay. Returned checks and outstanding balances older than 60 days may be subject to additional collection fee and finance charges at the rate of .66% monthly (7.92% annually). Charges may also be made for broken appointments and appointments cancelled without 24-hour advance notice. We do surcharge all credit cards a 3% fee. There is no surcharge on debit cards, checks, or cash. There is a 1.8% MN Care Tax from the State of MN Department of Revenue that is applied to all services rendered.

If you have dental insurance, you must bring proof of insurance, and we will be happy to submit your insurance claims for you. However, you must realize:

1.) Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.

2.) We cannot render services on the assumption the charges will be paid for by an insurance company. All charges are your responsibility from the date the services are rendered.

3.) Our fees are generally considered to fall within the acceptable range (U.C.R.) by most insurance companies and therefore are covered up to the maximum allowance determined by each carrier.

4.) Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover and will deny.

5.) Your copay is only an estimate. Your copay is due on the day of service. We can only estimate payment due based on your treatment plan given to you prior to scheduling.

6.) Upon receipt of the insurance payment, we will reconcile your account and bill or refund any difference.

7.) Please update our staff regarding any changes to your dental insurance policy, so that we may process your claim in a timely manner. We try to anticipate all costs prior to treatment. Unfortunately, treatment options may change during treatment and may add to your costs. We will make every effort to inform you before additional costs are incurred.

Thank you for your assistance in this important matter.

ACKNOWLEDGEMENT OF PRIVACY PRACTICES (HIPAA)

My signature confirms that I have been informed of my rights to privacy regarding protected health information under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). This document is available at the front desk for you. Key points include:

- The doctor will provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- The provider can obtain payment from third-party payers for my health care services (such as dental insurance)
- Conduct normal health care operations such as quality assessment and improvement activities

I, the patient, have been informed of my dental provider's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information.

Below are Minors or Dependent family members also covered by this acknowledgement (17 and under):

_____

_____

Acknowledgement of Forms & Policies

By checking the boxes and signing below, I am acknowledging that I have read and understood all of the following forms in this six-page packet. I have answered the above questions completely, accurately and to the best of my ability. I agree to all of the policies listed below.

☐ Patient Registration
☐ Medical History
☐ Records Release
☐ Cancellation Policy
☐ Financial Policy
☐ HIPAA Privacy

_____ _____

Patient/Guardian Signature Date