PATIENT REGISTRATION FORM

Today's date:_____

Patient name:_____ Birth date_____

Home phone: _____ Cell:_____ Work:_____ e-mail_____

Name(s) and relationship to patient of person(s) responsible for payment:

Full name of person responsible for payment: _____ Relationship: _____
Address:

_____

City_____ State_____ Zip Code_____
Social security number_____
Home phone: _____ Cell: _____ Work: _____ e-mail:_____ Name of Employer_____
Full name of other person responsible for payment: _____ Relationship: _____
Residential Address (If different from above):

_____

City_____ State_____ Zip Code_____
Date of birth_____ Social security number_____
Home phone: _____ Cell: _____ Work:_____
Name of Employer_____
Please provide the name of someone we may contact in case of emergency:_____

Please provide their home phone: _____ Cell:_____ Work #:_____

Primary Dental Insurance
Name of insured_____ Social security number_____
Insurance company_____ Group number _____
ID number _____ Insurance company phone_____
Insured's employer name _____ Insured's Occupation _____
Insurance company address_____

Secondary Dental Insurance
Name of insured_____ Social security number_____
Insurance company_____ Group number _____
ID number _____ Insurance company phone_____
Insured's employer name _____ Insured's Occupation_____
Insurance company address_____

Signature of person responsible for payment: _____
Printed name _____

If more than one person, not living in the same household will be responsible for payment, please include the other signature of person responsible for payment: _____
Printed name _____

If you received a dental benefits card, please bring this with you to your initial visit. If you need assistance completing this form, arrive a few minutes early and the receptionists will help you complete it. Please update your information with the receptionist when your insurance information changes. Thank you.

Medical & Dental History ***Patient Name*** _____ ***Date of birth*** _____

LIST CURRENT ALLERGIES: If you have over 3 allergies, write your allergies on the ***Meds and Allergies Form***:
Allergies:

LIST CURRENT MEDS: If you have over 3 meds (Prescription & non-prescription), list them on the ***Meds & Allergies Form***:

Name of Medicine: _____

Primary M.D.'s name _____ Their phone _____ City located _____

Mark the boxes below for conditions which you have or had:

☐ Acid reflux (GERD)	☐ Difficulty laying on back	☐ Pacemaker	☐Unexplained pain
☐ Alcoholism	☐ Drug Addiction	☐ Periodontal (gum) disease	☐ Unexplained swelling
☐ Alzheimer's	☐ Dizzy or Fainting spells	☐ Prolonged bleeding	☐Unusual weight loss or gain
☐ Angina / Heart pains	☐ Epilepsy or seizures	☐ Psychiatric care	☐Wake up gasping / choking
☐ Arthritis	☐ Fibromyalgia	☐ Radiation therapy	☐ Difficulty swallowing food
☐ Artificial Joint	☐ Fear of dental care	☐ Sinus Trouble	☐ Difficulty chewing food
☐ Artificial heart valve	☐ Frequent headaches	☐ Sleep apnea	☐ Grind teeth while sleeping
☐ Asthma	☐ Frequent jaw or neck pain	☐ Steroid use in the last 2 years _____	
☐ Autism	☐ Heart attack	☐ Stroke When? _____	
☐ Autoimmune disease	☐ Hepatitis / Liver Disease	☐ Thyroid disease or Parathyroid disease	
☐ Cancer	☐ Herpes (cold sores)	☐ TMJ or jaw joint problems or ringing in the ears	
☐ Chemotherapy	☐ **High Blood pressure**	☐ Tuberculosis (TB). Status: ☐active ☐ in remission	
☐ Diabetes (Type 1 or 2)	☐ Kidney / Renal Dialysis	☐ Unexplained fever, chills, night sweats	
☐ Difficulty getting numb	☐Lung disease/COPD/emphysema	☐ Unusual reaction to local anesthetic	

Circle either Yes or No. For a "Yes" answer, fill in the details for the follow-up question if present

Yes No Has it been over a year since you last saw a medical doctor? How many years since visit to see an m.d.? _____
Yes No Do you have an AUTOIMMUNE disease-what type(s)? _____
Yes No Have you had cancer? When and where? _____
Yes No **History of head, neck or oral cancer in your family?**
Yes No Did you have a heart surgery? When? _____
Yes No Do you have an artificial joint / implanted medical device? When was it placed? _____
Yes No **Do you have hemophilia, sickle cell, leukemia or another blood disorder?** Explain: _____
Yes No Do you feel constantly hungry or thirsty in the day time or do you have to go to the bathroom a lot at night time?
Yes No For Women: Are you or could you be pregnant at this time? What month? _____
Yes No Have you taken Fosamax or a bone enhancing drug or have you taken a diet pill like Fen Phen or Redux?
Yes No Do you sip soda or coffee with sugar in it or snack a lot during the day?
Yes No Do you smoke cigarettes or marijuana?
Yes No Do you consume more than 2 alcoholic drinks on a daily basis? How many? _____
Yes No Were you hospitalized in the past 2 years? Explain nature of hospitalization(s) _____

Yes No Do you have any serious medical condition not listed on this form or would you like to add anything to your medical or dental history? Please list or describe _____

If possible, complete this form in advance and bring it to your initial appointment. If you have dental insurance, bring that information also. Arrive 30 minutes early to complete paperwork if not done in advance. Do not email or fax back any forms containing your health information. Your signature below indicates you understand the form and completed it accurately:

Patient / guardian's signature _____ **Print name** _____ **Date** _____

Medicines & Allergies Form **Patient name**_____ **D.O.B.**_____

Yes No Any changes in your health, dental coverage, name, address or contact information?

Yes No Blood pressure reading taken with the past 6 months? BP ☐ R ☐ L _____/_____ Sitting.

BP ☐ R ☐ L _____/_____ Sitting.

*List your allergies including any allergy to penicillin, latex, metal or codeine. If you're not allergic, staff will draw a line through the entry and write "**NA"(No Allergy), along with the** date it was crossed off the list and their initials.*

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____

List prescription & non-prescription medications, including dietary supplements, vitamins. Use one line for each entry.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____
19. _____
20. _____

For staff members only: If stopped using med, write "OFF" or if wrong med, "WRONG" after it. Then draw a line through med, date & initial.

21. _____
22. _____
23. _____
24. _____
25. _____
26. _____
27. _____
28. _____
29. _____
30. _____
31. _____
32. _____
33. _____
34. _____
35. _____
36. _____
37. _____
38. _____
39. _____
40. _____

REQUEST FOR TRANSFER OF RECORDS

To the office of Doctor _____

Name and address and phone # (if available) of dental office from which records are requested:

_____

_____

_____

RECORDS FOR PATIENT: _____ PATIENT'S D.O.B._____

The patient listed above has opted not to pick up their dental records in person. Rather, they have opted to provide this authorization requesting the following dental records be provided to Dr. Day in the manner checked on the list below:

_____ e-mail the information requested to Dr. Day at his e-mail listed above.

_____ mail copies of requested records to Dr. Day's office at the address listed above.

_____ I give my permission for the following person(s) to pick up by the requested information:

Please provide the following: Copies of latest _____BW's _____FMX _____ Panorex

Date of last exam _____

Date of last prophylaxis _____

Other:_____

_____

_____

I, _____,expressly permit the above dental office to release the following dental records to Dr. Day and I understand my Protected Health Information (PHI) will not be released to anyone other than the individual(s) listed on this form as indicated by one of the following means of communication (Methods approved by patient have been checked above).

Signed_____ Date_____ Printed name of patient_____

OFFICE FINANCIAL POLICY FOR JOHN DAY, DDS

If you would like a treatment plan including the estimated cost of your current or upcoming visit, please discuss this with the receptionist or other staff.

We will provide a "walkout statement" when a co-pay payment is made. Please ask the receptionist for a walkout statement if you want to see charges, estimated co-pays, etc.

Full payment is due upon receipt of the monthly billing statement unless a payment plan has been developed. We understand it is not always possible to pay your dental bill in full so we have payment options. Please call us as soon as possible to set up a payment plan in order to avoid collection efforts. If you have an unpaid balance, and have a payment plan, you will receive a monthly statement detailing recent payments, charges and the existing balance on your account.

Unless you are following a payment plan approved by the office staff, amounts not covered by insurance will be paid in full on the day of the dental visit. Returned checks: Bank service fees will be charged for any returned check (The amount depends on the bank). Broken appointments: Our practice may charge you up to $50 for an appointment broken without proper 24 hour weekday notice. We understand emergencies occur. However, we want to make the appointment available for other patients.

If you have dental insurance, and don't bring the required insurance information, we may be unable to determine if we accept your insurance, or if the procedure is a covered insurance benefit. If there is uncertainty whether we accept the insurance, we will advise you of this. We accept most, not all dental insurances. We recommend you reschedule until we can determine if your insurance covers the planned treatment. If you wish to proceed with planned treatment, even if it is not a covered by insurance or we cannot receive insurance benefits for a procedure, you will be responsible for the unpaid balance**. We may proceed with treatment at your request but the unpaid balance will be your responsibility.** If you overpay, we will send you a refund check for the amount in excess of the dental fees after insurance has paid. We are not the insurance company. The insurance company works with you and the employer. Insurance companies vary greatly on how much they cover different dental procedures. We can only estimate what we expect they will cover for your dental treatment. If your claim is denied or the treatment is down-coded and/or alternative benefits given, you will be responsible for paying the unpaid balance on your account and determining if you wish to proceed with planned treatment or choose an alternative treatment.

By signing below, I am stating I understand the above information and agree if for any reason my insurance plan does not cover what has been estimated, I know I am responsible for payment of the remaining balance.

Patient's signature_____ Today's date_____ Staff initials_____

Printed name_____

PATIENT CONSENT FORM

I understand under the **Health Insurance Portability & Accountability Act of 1996 (HIPAA),** I have certain rights to privacy regarding my protected health information. I understand this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physicians certification.

I have been informed Dr. Day's *Notice of Privacy Practices* contain a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand this organization has the right to change its *Notice of Privacy Practices* from time to time and I may contact this organization at any time at the office address or phone number above to request and obtain a current copy of the *Notice of Privacy Practices*.

I understand I may request in writing the way you restrict my private information as well as how it is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

When a dental office creates its HIPAA forms, it is a requirement to allow patients the right to revoke the some or all of the permissions they have given to disclose their private dental information to certain parties. With this in mind, I understand I have the right to revoke any portion of this consent at any time, except to the extent already taken on actions relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____ Date: _____

John Day, DDS 1801 E. Saginaw St. #3, Lansing 48912 (517) 484-3310 *jdayfamilydds@gmail.com*

CONSENT TO COMMUNICATE PHI BY EMAIL: I expressly permit John Day, DDS and staff (Dr. Day's office or Dr. Day) to communicate my Protected Health Information (PHI) via email to the e-mail address indicated on my Patient's General and Emergency Contact Information form, or as found on this form. If you do not wish to communicate by email, you may leave this page blank.

MAIL RISKS AND YOUR RESPONSIBILITY: If you agree to permit Dr. Day's office to use e-mail to communicate with you, you should be aware of the following risks and/or your responsibilities:

The internet is not secure or private, unauthorized people may be able to intercept, read and possibly modify email you send or are sent by Dr. Day. You should be careful regarding whom you send e-mails. We advise you protect your e-mail account, password and computer against access by unauthorized people. Please do not include personal identifying information such as your birth date or personal medical information in any emails you send to us.

CONDITIONS FOR THE USE OF E-MAIL: By consenting to the use of e-mail with Dr. Day, you agree that:

-Dr. Day may forward e-mails as appropriate for diagnosis, treatment, reimbursement, and other related reasons. Dr. Day's office and other agents, other than the recipient, may have access to e-mails that you send. Such access will only be to persons who have a right to access your e-mail to provide services to you.

-Dr. Day and staff will not forward e-mails to independent third parties without your prior written consent, except as authorized or required by law.

-You should not use e-mail to communicate with Dr. Day and staff if there is an emergency or where you require an answer in a short period of time.

-If your e-mail requires or asks for a response, and you have not received a response within a reasonable time period, it is your responsibility to follow up directly with Dr. Day's office either by phone or mail or a visit to the office.

-You should carefully consider the use of e-mail for the communication of sensitive medical information, such as, but not limited to, information regarding sexually transmitted diseases, mental health, substance abuse or developmental disability and do not send social security numbers over unencrypted e-mails.

-Dr. Day's office reserve the right to save your e-mail and include your e-mail or information contained within your e-mail in your dental record.

The federal government clarified the HIPAA regulations allow dental offices to use unsecure email to send information to a patient as long as the patient requested it be sent that way.

INSTRUCTIONS: You should immediately inform Dr. Day's office if you change your e-mail address.

-If you wish to withdraw your consent to communicate by e-mail, send an e-mail to Dr. Day's office or call us or provide a written letter to inform us of such or indicate you wish to withdraw your consent to one of the staff or Dr. Day and we will note this in your records.

ACKNOWLEDGMENT AND AGREEMENT: Dr. Day's office will use reasonable means to protect the privacy of the patient's health information. However, because of the risks outlined above, Dr. Day's office cannot guarantee that e-mail will be confidential. Additionally, Dr. Day will not be liable in the event that your or anyone else inappropriately uses or accesses your e-mail. Dr. Day will not be liable for improper disclosure of your health information that is not caused by the intentional misconduct of Dr. Day's office.

By signing below, I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communications of e-mail between Dr. Day's office and me, and consent to the conditions outlined herein, as well as any other instructions that Dr. Day may impose to communicate with me by e-mail. Any questions I may have had were answered. I understand that this consent is valid until such time as I revoke the consent as outlined above, except to the extent that a person who is to make a communication has already acted in reliance upon this authorization.

Signed:_____ Printed:_____ Date:_____

E-mail Address_____ Patient #_____ (for office use only)

Please advise us of any changes to your email or if you no longer wish to receive texts or emails and we will indicate such on this form. Either do this by phone, mail or email or in person. Thank you for taking time to complete these forms.

Patient's General and Emergency Contact Information

Patient name _____ Name prefer to be called_____

How did you hear about this office? _____ .

_____I read the "Notice regarding HIPAA compliant electronic communications and protected health information" from Dr. Day's office. I understand if I consent to communicate by electronic communication, such as for appointment reminders, there is a slight risk in unencrypted emails as they may be intercepted by a third party. Please indicate if you wish to be contacted by Dr. Day's office in the following manner (check all areas that apply, otherwise leave blank):

_____ Please do not call me at home or work to remind me about appointments.

_____Please do not call me at work to remind me about appointments or other matters.

_____Please contact me on my home telephone: (____) ____ - _____

_____Please contact me on my cellular phone: (____) _____ - _____

_____Please contact me on my work phone: (____) _____ - _____

_____ I prefer a phone call a day or two prior to my appointment to remind me.

_____ When you call, comment "this is your dentist's office" only and don't leave your phone number.

_____You can leave a detailed message, including office name and phone # when you call.

_____ I prefer receiving a post card in the mail reminding me about upcoming appointments.

_____Provider can mail or email me information such as appointment reminders or clinical information to

(circle those which apply): a.) home b.) work c.) to this address _____.

_____***I give permission to staff at Dr. Day's office to release dental information to***

_____ and _____(Leave blank if doesn't apply).

_____ I authorize the above person or person(s) to get my dental records by mail or in person.

_____ I authorize the above person or person(s) to get my dental records in person only.

In case of an emergency, I authorize Dr. Day's office to contact_____.

Please provide us with an emergency contact number to notify this person _____.

My relationship to this contact is _____.

Patient's name (please print) _____ Today's date_____

Signature of patient if an adult, or of parent or legal guardian_____

Printed name of parent or legal guardian if patient is a minor_____