PATIENT REGISTRATION

ID: _____ Chart ID: _____

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder Preferred Name: _____

☐ Responsible Party

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.

_____ Section 2 _____ Section 3 _____

ME: _____

Employment Status: ◯ Full Time ◯ Part Time ◯ Retired

Student Status: ◯ Full Time ◯ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: .00 Rem. Deduct: _____.00

Dr. Jon McDonald DDS

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

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, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

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 Problem ◯ 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 _____

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 _____ DATE _____

LOS ALAMOS DENTAL

Jon McDonald, DDS

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Los Alamos, NM 87544
(505) 662-2426
Email: office@jonmcdonalddds.com
Website: www.jonmcdonalddds.com

Professional Service and Fees

Dr McDonald and his staff are committed to providing you with the best care possible and welcome the opportunity to discuss fees pertaining to your treatment needs. Your clear understanding of both your treatment and your financial responsibility is very important to us.

Payment for dental treatment is due and payable at the time the service is rendered. For your convenience we accept cash, personal check, Visa, MasterCard, Discover, and American Express. We also have out-of-office financing available which, after approval, offers affordable monthly payment.

Once you have discussed treatment options with Dr McDonald you will be given a treatment estimate. You can then schedule an appointment. Payment for services rendered are due at the time of treatment.

Should we receive a returned check from your banking institution, an insufficient funds charge of $20.00 will be applied to your account.

In the case of default of payment, you are responsible for all legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collections of this account and of future outstanding accounts.

General Office Policies

Informed Consent:

I understand that I will be informed of my dental ailment, treatment options, benefits, substantial risk, and consequences of limited or non-treatment. I consent to and authorize dental services to be performed. I understand that at any time I may terminate or postpone dental treatment.

Photograph Consent:

I give permission to LOS ALAMOS DENTAL to use my photographs as needed for insurance purposes.

Broken or Missed Appointments:

Our office understands that life is busy for all of us and there are times when circumstances arise that are beyond one's control. However, when an appointment is reserved with our office and patients fail to come in for that appointment or cancel with little to no notice, we still have to pay our staff and all the hard costs involved with a dental appointment. Not to mention that we have other patients waiting to be seen earlier, if possible, that could have utilized the time.

Since we do not wish to increase fees to cover these costs, thus penalizing all patients for the actions of others, there will be a flat fee assessed to all accounts when an appointment is broken/missed. The fee assessed for a broken/missed appointment with Dr McDonald will be $50.00 per half hour. Any appointments broken/missed with our hygiene department will be $100.00 per hour.

Our Dental Office reserves the right to charge for each broken/missed appointment if 24 business hours notice is not given. Leaving a message after hours for the following day does not constitute 24 business hours since our office will not receive the message until 7:30 a.m. the next business day. The office will attempt to reach you to remind you of your appointment as a courtesy, but the appointment is considered confirmed when it is made.

We may leave a message on your home, work, cell phone or email address to confirm appointments or inform you of results of testing, pre-determinations from your insurance company, or for some other operational or informational reason.

Dental Insurance

If you have dental insurance, we will help you receive your maximum allowable benefits. We will gladly discuss your treatment and answer any questions relating to your insurance to the best of our ability, As a courtesy, we will file your claims, but will not accept responsibility for negotiating any settlement on disputed claims.

Our fees are generally considered to fall within the acceptable (reasonable and customary) range for most insurance companies. This does not apply when we file as an out-of-network provider or when insurance companies, reimburse on an arbitrary "Fee Schedule", which bears no relationship to the current standard and cost of care in this area.

The objective of an insurance company is to collect premiums and not pay out any more than necessary on your behalf. Please remember that not all services are a benefit of your contract. Insurance companies base their treatment expectations on dental treatment considered acceptable in the 1950's and 1960's. These expectations can change from one year to the next based on the payment made by them the previous year.

I understand that my dental insurance is a contract between my insurance carrier and me and **NOT** between the insurance carrier and LOS ALAMOS DENTAL; therefore, I am still responsible for **ALL** dental fees. I understand that I will be charged for all dental treatment and that any payment received by the Dental office from my insurance company will be credited to my account and refunded to me if I have paid the dental fees incurred.

Authorization

I hereby authorize LOS ALAMOS DENTAL to administer such medication and perform such diagnostic, photographic, and therapeutic procedures as may be necessary for proper dental care. The information on my dental and medical histories is correct to the a best of my knowledge. I grant the right to LOS ALAMOS DENTAL to release my dental/medical histories and other information about by dental treatment to third party payers and/or other health professionals.

LOS ALAMOS DENTAL
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Acknowledgment of Privacy Rights

My signature below confirms that I understand and acknowledge that I have read, understand, and agree to Professional Services and Fees, General Office Policies, Dental Insurance, and Authorization policies. It also confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number health care providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers for my health care services
- Conduct normal health care operations such as quality assessment and improvement activities

I 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. I have been given the right to review such Notice of Privacy Practices and I understand that I may contact this office at the address above to obtain current copy of the Notice of Privacy Practices.

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

Print Name: _____ Date: _____

Signature: _____

Relationship to Patient: _____

Dependent family members (**who are under the age of 18**) also covered by this acknowledgment:

_____

_____

Please list numbers below that we are able to leave messages on regarding appointments:

Home: _____ Cell: _____ Work: _____

Email Address: _____

Emergency Contact Information

Name: _____ Relationship: _____

Phone Number(s): _____