Magnus Dentistry - Patient Registration, Consent, and Financial Policy

Patient Name (First, Middle, Last) _____ Date_____

Address_____City_____State_____Zip_____

Date of Birth_____ Social Security #_____Marital status M/S/D/W

Cell # ( ) _____ Home# ( ) _____ Work # ( ) _____

E-Mail address_____

Person Responsible for account_____

Dental insurance: Yes No

Name of Policy Holder_____ Relationship to Insured_____

Employer_____ Insurance Company_____

Insurance ID or Social Security #_____ Date of Birth_____

Secondary Dental Insurance: Yes No

Name of Policy Holder_____ Relationship to Insured_____

Employer_____ Insurance Company_____

Insurance ID or Social Security #_____ Date of Birth_____

Emergency Contact Name: _____ Relationship_____ Contact #_____

Who may we thank for referring you				
Do you have any present dental problems				
How do you rate your smile?		Like to Change	It's OK	Love it
Do you avoid brushing any area of your mouth			YES NO	
Do your gums bleed when you brush			YES	NO
Are your teeth sensitive:	Hot/Cold		YES	NO
	Sweets		YES	NO
	Biting		YES	NO

Patient Signature _____Date_____

PLEASE READ AND SIGN NEXT PAGE

Consent for Treatment and Financial Policy:

I hereby authorize Dr. Magnus and/or designated staff to take necessary radiographs, study models, photos, and other diagnostic aids needed to make a thorough diagnosis of my oral condition in order to determine possible treatment needs. I authorize Dr. Magnus and staff to perform these treatment procedures after an in-depth explanation and an opportunity to ask questions. I understand that any dental procedure has risks involved including but not limited to: reactions to anesthetics (i.e., bruising, heart rate changes, and temporary or permanent 'numbness); change in 'bite'; increase in tooth sensitivity after treatment; soreness of the teeth and jaw joint; possibility of infections undetected at time of treatment; need for follow-up care and possibly follow up care and possibly further treatment. All efforts will be made to minimize such risks but I do assume these when undergoing dental care by Dr. Magnus and staff. I understand that no warranties are made as each person is individual and their bodies respond differently so each outcome cannot be specifically guaranteed.

I accept full responsibility for the payment of dental service provided by this office. I realize that dental claims are filed for me as a courtesy only. I will be given an estimate of costs which includes fees assumed to be paid by my insurance as well as the portion expected of myself. My portion of fees is due at the time of service and will not be billed. The estimate(s) given to me is based on information given to this office from my insurance company and is never a guarantee of final cost or payment from my insurance company. All reasonable efforts will be made to collect from my insurance company. If my account for dental procedural fees is not paid in full within 60 days, it is subject to billing fees by this office, collection agency fees, and any legal fees incurred by this office in order to acquire my promised payment.

You agree to reimburse us the fee of any collection agency, which may be based on a percentage at a maximum of 50% of the debt, and all cost, and expenses including reasonable attorney's fees, we incur in such collection

All appointments require 24 hours' notice of cancellation. There is a $75-$150 charge for short notice cancellation

Patient Signature (Parent/Guardian)_____Date_____

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 If yes, please explain: _____

Are you on a special diet? Yes No

Do you use tobacco? Yes No

Do you use controlled substances? Yes No

Do you need to pre-medicate? Yes No If yes, please explain: _____

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 Acrylic Metal Latex Local Anesthetics

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	Renal Dialysis	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Rheumatic Fever	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Rheumatism	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Scarlet Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Shingles	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	Hives or Rash	Yes	No	Sickle Cell Disease	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hypoglycemia	Yes	No	Sinus Trouble	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Irregular Heartbeat	Yes	No	Spina Bifida	Yes	No
Asthma	Yes	No	Fainting Spells/Dizziness	Yes	No	Kidney Problems	Yes	No	Stomach/Intestinal Disease	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Leukemia	Yes	No	Stroke	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Liver Disease	Yes	No	Swelling of Limbs	Yes	No
Breathing Problem	Yes	No	Frequent Headaches	Yes	No	Low Blood Pressure	Yes	No	Thyroid Disease	Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Lung Disease	Yes	No	Tonsillitis	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Mitral Valve Prolapse	Yes	No	Tuberculosis	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Pain in Jaw Joints	Yes	No	Tumors or Growths	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Murmur	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disorder	Yes	No	Heart Pace Maker	Yes	No	Radiation Treatments	Yes	No	Yellow Jaundice	Yes	No
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Recent Weight Loss	Yes	No			

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

_____

_____

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 _____

Acknowledgement of Receipt of HIPAA Notice & Privacy Practices

I, _____, hereby acknowledge that I have received and reviewed a copy of

Magnus Dentistry's HIPAA Notice of Privacy Practices.
I understand that Magnus Dentistry's HIPAA Notice of Privacy Practices may change periodically and that I am entitled to receive a copy of Magnus Dentistry's revised HIPAA Notice of Privacy Practices upon request.

I understand that, if I have questions about Magnus Dentistry's HIPAA Notice of Privacy Practices, I may contact the privacy official at Magnus Dentistry.

I understand that it is my right to refuse to sign this Acknowledgement should I so choose, and that Magnus Dentistry will not refuse treatment to me if I refuse to sign this Acknowledgement.

I further understand that I may contact the Secretary of the U.S. Department of Health and Human Services should I have concerns regarding Magnus Dentistry's privacy policies and procedures.

_____ *Signature of Patient*

_____ / _____ / _____ *Date*

_____*Signature of Responsible Party*

_____ / _____ / _____ *Date*

OR

_____ *Printed Name of Responsible Party Relationship*

_____ / _____ / _____ *Date*

_____ *Signature of Staff Member*

_____ / _____ / _____ *Date*

HIPAA Information Communication Release

The HIPAA privacy law dictates that we are only authorized to communicate with patients themselves, guardians, insurance providers and patients' physicians, unless we have authorization in writing by the patient to communicate with others on their behalf. Please provide all family members or friends you want us to be able to speak with. Spouses are not automatically included; their names must be explicitly stated below. You may opt out by checking the "DO NOT RELEASE INFORMATION" box below.

I give the following named person(s) authorization to take messages or speak with the office of Perfect Smiles Dental Care on my behalf, regarding (please check all items authorized). Please note that information will be shared with these parties on a strictly "as needed" basis.

NAME OF AUTHORIZED PERSON(S): _____ Relationship: _____ Phone Number: _____ Able to Discuss (circle all that apply):

Appointments: Y | N Financial: Y | N Dental Treatment: Y | N Insurance: Y | N Medical History: Y | N Other: _____

NAME OF AUTHORIZED PERSON(S): _____ Relationship: _____ Phone Number: _____ Able to Discuss (circle all that apply):

Appointments: Y | N Financial: Y | N Dental Treatment: Y | N Insurance: Y | N Medical History: Y | N Other: _____

DO NOT RELEASE INFORMATION TO ANYONE: _____ (Initial)

I understand that my express written consent is required to release any health care information. With my signature below, I acknowledge and understand that this information will be kept in my medical record and the above parameters will remain in effect until revoked by me in writing. It is my responsibility to notify my healthcare provider(s) should I wish to change one or more contact listed above.

Patient's Name: _____ Date: _____

Signature of Patient or Authorized Representative:

_____