DENTAL ASSOCIATES OF CAPE COD - PATIENT REGISTRATION

Patient's Legal Name_____ **Today's Date:**_____
Last First M.I.

Name you preferred to be called (if any) _____

Birth Date_____ Sex: (Please Circle) Male Female So. Sec. #._____

Home Phone _____Cell Phone_____E-Mail:_____

Patient's Address_____
Street City State Zip Code
Mailing Address (if different) _____

Length at present address_____Marital Status_____Driver's License #_____

Patient's Employer_____Position_____Length at present employer_____

Employer's Address_____Work phone_____Ext_____Dept_____

Nearest relative not residing with you_____Phone_____Relationship to patient_____

If Student: Full time Part time Name of Institute_____City_____State_____

In case of emergency please contact: Name_____ Phone_____ Relationship_____

Who will pay this account? (Whose name will appear on billing statement) Self Spouse Parent/Guardian
If you checked "self" Please skip next section.

PERSON RESPONSIBLE FOR THIS ACCOUNT OTHER THAN ABOVE NAMED PATIENT

Responsible Party's Name_____Soc. Sec. #_____
Last first m.i.
Address_____Phone_____
street city state zip code
Employer_____Address_____Work Phone_____
street state

Your relationship to Responsible Party:_____

Signature of Responsible Party:_____

REFERRAL

How did you hear about our office? DentalCapeCod.com FaceBook Google Invisalign.com Radio

Internet Search Dental Insurance Company Verizon Yellow Pages Walk-In

Other: _____
If from a current patient of ours, please give us their name so we can thank them:

_____

* Please read and sign acknowledgment of HIPAA laws on reverse →

DENTAL ASSOCIATES OF CAPE COD - CONSENT TO PRIVACY PRACTICES

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Business Assistant
Telephone: 508-778-1200
Fax: 508-775-5502
Address: 262 Barnstable Rd.
Hyannis, MA 02601

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected heath information to carry out treatment, payment activities and health care operations.

*** Signature: _____ Date:_____**

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ❑ **Individual refused to sign**
- ❑ **Communications barriers prohibited obtaining the acknowledgement**
- ❑ **An emergency situation prevented us from obtaining acknowledgement**
- ❑ **Other (Please Specify)**

Patient Dental History and Smile Analysis

Name:_____Date:_____

Reason for today's visit:_____

Name of previous dentist:_____

Date of last dental x-rays:_____ What x-rays were taken:_____

Date of last dental care:_____ Treatment received:_____

Circle "Y" or "N" for the following conditions:

Y	**N**	**Bad breathe / taste**	**Y**	**N**	**Loose or broken teeth**
Y	**N**	**Sensitivity to hot/cold/sweets/biting**	**Y**	**N**	**Periodontal gum / treatments**
Y	**N**	**Bleeding gums / sore gums**	**Y**	**N**	**Swelling / lumps in mouth**
Y	**N**	**Dry mouth**	**Y**	**N**	**Sores in your mouth**
Y	**N**	**Shifting of teeth / bite**	**Y**	**N**	**TMJ pain / clicking / popping in jaw**
Y	**N**	**Food Collection between teeth**	**Y**	**N**	**Do you wear dentures / partials**

Is there a history of gum/periodontal disease in your family? ____Yes _____No

Do you smoke? _____Yes _____No If yes, how much?_____

How often do you brush your teeth?_____Floss your teeth?_____Use mouthwash?_____

Do you use manual or electric toothbrush?_____

Smile Analysis

Do you like the color of your teeth? ___Yes ___No

Do you wish your teeth were whiter? ___Yes ___No

Do you wish your teeth were straighter? ___Yes ___No

Do you feel there is too much space in between your teeth? ___Yes ___No

Do you know all of the options available for enhancing your smile? ___Yes ___No

Do you feel that finances have prevented you from taking advantage of some of the options available to enhance your smile? ___Yes ___No

_____ _____

Patient Signature Date

Name:_____ Date:_____

In the following questions, circle or check YES or NO whichever applies. Your answers are for our records and will be considered confidential.

1. Are you in good health ?---------- YES NO

2. Are you now under the care of a physician ?---------- YES NO

3. The name of my physician_____Phone_____

Address_____

4A. Have you had any joints replaced ?----------YES NO

If so, what_____When?_____4B. Do you need to pre-medicate prior to dental procedures YES NO

5. Do you have or have you had any of the following diseases or problems? :

	YES	NO		YES	NO
Heart Attack / Stroke			**Psychiatric Problems**		
Cancer / Chemotherapy			**Epilepsy / Seizures / Fainting spells**		
Heart Murmur			**Diabetes / Tuberculosis (TB)**		
Previous Endocarditis			**Drug / Alcohol Abuse**		
Rheumatic Fever			**Venereal Disease**		
HIV + / AIDS			**Hemophilia / Abnormal Bleeding**		
Heart Surgery / Pacemaker			**Ulcers / Colitis**		
Shingles			**Congenital Heart Defect**		
Mitral Valve Prolapse			**Anemia / Radiation Treatment**		
Kidney Problems			**Asthma / Arthritis**		
Artificial Bones / Joints			**Difficulty Breathing**		
Artificial Valves			**Hospitalized for Any Reason**		
Sinus Problems			**Hepatitis**		
High Blood Pressure			**Blood Transfusion**		
Low Blood Pressure			**Emphysema / Glaucoma**		
Severe / Frequent Headaches			**Other:**		

6. Are you taking any of the following? :

	YES	NO		YES	NO
Antibiotics or sulfa drugs			**Aspirin**		
Anticoagulants (blood thinners) Name:			**Insulin, Tolbutamide (Orinase)**		
Medicine for high blood pressure			**Digitalis or drugs for heart trouble**		
Cortisone (steroids)			**Nitroglycerin**		
Tranquilizers			**Oral Contraceptive** (hormonal therapy)		
Antihistamines			***Other-Including Vitamins and Herbs (Please List)***		

7. Are you allergic or have you reacted adversely to? :

	YES	NO		YES	NO
Penicillin			**Dental Anesthetics**		
Aspirin			**Codeine**		
Erythromycin			**Latex**		
Tetracycline			***Other (list)***		

8. Do you have any disease, condition or problem not listed above that you think I should know about? If so, please explain._____ YES NO

Women

9. Are you pregnant?---------- **YES NO**

10. Are you nursing?---------- **YES NO**

OFFICE POLICIES

WELCOME to our office. We are happy to have you as a patient. In an attempt to maintain our fees at a reasonable level, we ask you to help us by observing the following:

BROKEN APPOINTMENTS - If you cannot keep your appointment, we ask for a 48-hour notice to avoid a possible missed appointment charge of $35.00 per ½ hour appointment. This fee is not covered by ANY insurance; therefore, you would be directly responsible.

ACCOUNTS ARE DUE AND PAYABLE ON RECEIPT OF SERVICES - Payment in full for all services is expected the day that they are rendered, unless previous arrangements have been made. Master Card, Visa and American Express are welcome.

DENTAL INSURANCE - Patients who have dental insurance are expected to pay their deductible and any co-payments in full at the time of service. Please realize that professional services are rendered to a person, not to an insurance company. Our office will attempt to get an overview of your dental coverage from your insurance company. This information will be used to calculate your expected co-payments. Please be aware that YOUR insurance company makes the final decision on what is paid on claims submitted to them by our office. Most insurance companies have a yearly maximum amount that they will pay for each individual family member. Once this maximum is reached any additional charges will be the responsibility of the patient. Your insurance company should be able to provide you with accurate information regarding available benefits for the year. You are ultimately responsible for all fees.

The undersigned hereby authorizes doctor/staff to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate. I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquires set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

* ______________________________ ____________

Signature of Patient ***Date***

* ______________________________ ____________

Signature of Dentist ***Date***

^^

Please read the following carefully and sign below.

I understand that a service charge of 1 ½% per month on the unpaid balance (18% Annual Percentage Rate) will be charged on all overdue balances, unless previous written and signed payment arrangements have been made.

I also understand that I am financially responsible for all balances incurred in this office, by my dependents or myself. I understand that if collection procedures are necessary to collect any outstanding balance, that I will be financially responsible for the entire cost of all collection procedures.

* ______________________________ ____________

Signature of Responsible Party ***Date***

Dental Associates Of Cape Cod **- Insurance Authorization**

Subscriber's Legal Name _____ Date of Birth:_____

Last First MI

Employer_____ Phone_____

Employer's Address_____

Insurance Company Name_____ Phone_____

Insurance Address_____

ID#_____Group #_____ Soc Sec # _____

Patient relationship to subscriber: Self _____ Spouse _____ Dependent _____

I_____, understand and agree that I am responsible for all charges incurred regardless of insurance coverage. I understand that *Dental Associates Of Cape Cod* has accepted the insurance company's verification of coverage and benefits in good faith that the claim will actually be covered as described by the insurance company. In the event that the insurance company does not cover the claim for the verified benefits, I agree to be responsible for all charges for dental services and materials, which I and/or my dependents have incurred and authorized in my and/or my dependents' treatment. I agree that any balance not paid by my insurance company within 60 (sixty) days will be my responsibility to pay. I agree to furnish the insurance company and *Dental Associates Of Cape Cod* with any additional information or paperwork requested to expedite payment of my claim. To the extent permitted under applicable law, I herby assign and authorize payment of dental benefits otherwise payable to me, directly to the office of *Dental Associates Of Cape Cod.* I agree that a photocopy of this document and authorization may act as an original and that my signature below shall authorize payment to the dentist for any services rendered to my dependents or me as if I had signed each benefit assignment of future claims.

*** I also understand that Dental Associates Of Cape Cod (Dr. Michael Seidman and Dr. Janet Butts) use composite ("tooth colored) restorations unless otherwise requested. We invite all patients to check with their insurance carrier for coverage differences, if any, between composite and amalgam (silver) restorations**

*** I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment. I hereby authorize payment directly to the office of *Dental Associates Of Cape Cod* the group insurance benefits otherwise payable to me. This "Signature On File" will be valid from this date forward. A photocopy of this document may act as an original.**

_____ _____

Today's Date **Signature Of Insured** (or Parent/Guardian if Minor)

Automated Appointment Reminders

Patient Name:_____ Date:_____

We are pleased to announce the use of Smile Reminders to send you appointment confirmation and reminders by text and e-mail.

_____

E-mail address

_____

Phone Number for Text Messages

- - OR - -

If you do NOT use e-mail and/or text messaging we will remind you with a voice mail on your home phone.

_____

Home Phone Number for Voice Messages

Our office considers ALL appointments scheduled to be confirmed. Please be aware that the automated confirmation system does not accept changes in the schedule or cancellations. All changes must be made by calling the office directly. Our office does require 48 hours notice for any schedule changes.

By signing below, you give our office permission to leave basic information regarding your appointments at the above phone numbers and e-mail address.

_____