PATIENT REGISTRATION

{Please print}

Date______________________ Sex: M ◯ F ◯

Patient Information: ____
First Name Last Name Preferred Name

Mailing Address______________________________City_______________ State______Zip________

Home Phone ______________________________ Cell Phone______________________________

Age _______ Birthdate ____________________ Social Security #______________________________

Employer______________________________Work Phone______________________________

INSURANCE INFORMATION

Primary Dental Insurance Company____

Group #____________________ Group Name (Employer) ______________________________

Subscriber's Name______________________________ Relationship to patient____________________

Social Security # or Subscriber ID #______________________________Birthdate ________________

Secondary Dental Insurance Company____

Group #____________________ Group Name (Employer)______________________________

Subscriber's Name______________________________ Relationship to patient____________________

Social Security # or Subscriber ID #______________________________Birthdate ________________

I authorize release of any information relating to my dental insurance claims. I hereby authorize payment of dental benefits otherwise payable to me directly to Dr. Gregory Zlock.

Signature____ **Date**______________________

Who is responsible for payment of this account? ____________________Relationship to patient ____________

In case of emergency, who should be notified? ______________________ Phone ____________________

I acknowledge responsibility for payment of services rendered and agree to pay for them in full. I understand that any balance over 60 days will incur annual interest penalty of up to 15%. If the account becomes past due, I understand that I am personally responsible to pay all collection fees associated with the account, including reasonable attorney and reasonable agency fees. I understand that in the event my account is turned over to a third party collection agency, a collection fee of up to 50% of my total account balance will be added to my balance, and that I am responsible to pay that amount. By providing a mobile/cell number, I authorize the use of contact through that number for any activity involving our services to you, including but not limited to the resolution of the balance of the account. The number will not be shared with any party other than those in-house or any business entity contracted to perform duties resulting from services provided to you by this office.

Signature____ **Date**______________________

MEDICAL HISTORY

{The following answers are for our records only and will be considered confidential}

Patient Name: ____Date of Birth: ____________________

Your Physician's Name: ____

Have you ever had any of the following?
(Check boxes that apply):

- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Disease
- ☐ Bone Infection
- ☐ Diabetes
- ☐ Emotional Disturbances
- ☐ Epilepsy
- ☐ **Heart Disease**
- ☐ **Heart Murmur**
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV positive test
- ☐ Liver/Kidney Disease
- ☐ Osteoporosis
- ☐ Pace Maker
- ☐ Radiation Therapy
- ☐ Respiratory Disease
- ☐ **Rheumatic Fever**
- ☐ Stomach Disease
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Tumors/Cancer
- ☐ Venereal Disease

Y ☐ N ☐ Are you currently under medical treatment? If yes, please explain____

____

Y ☐ N ☐ Have you been hospitalized in the past five years? If yes, please explain____________________________________

____

Y ☐ N ☐ Have you had any surgeries? ____

Y ☐ **N** ☐ **Heart surgery?** ____

Y ☐ **N** ☐ **Have you had any joint replacements, received implants or donors?** ___________________________________

Y ☐ **N** ☐ **Have you had any reactions to any medications?** If yes, please explain____________________________________

____

Y ☐ N ☐ Are you currently taking any medications or drugs? If yes, please explain___________________________________

____

Y ☐ **N** ☐ **Are you sensitive to metals, latex, or other materials?** If yes, please explain______________________________

____

Y ☐ N ☐ Do you smoke or use smokeless tobacco? How much per day? ____

Y ☐ N ☐ Are you pregnant? Due date____________________________________

DENTAL HISTORY

Last dental visit: Month________________Year________________Reason____

Previous Dentist: ____City, State: ______________________________________

Y ☐ N ☐ Have you had local anesthetic? Y ☐ N ☐ Do you have any sores, growths or spots in your mouth?

Y ☐ N ☐ Do you have a specific dental problem? ____

What, if anything, would you like to change about your smile? ____

____

Would you like to have a whiter smile? ____

Have you had any prior dental experiences that we should be aware of? ____

____

I hereby give my consent for dental procedures for myself or for ____. I also give my consent to any advisable and necessary dental procedures, medications or anesthetics to be administered by Dr. Greg Zlock and his supervised staff. I certify that the above answers are accurate and complete to the best of my knowledge.

Signature____ **Date**________________________________

FINANCIAL AGREEMENT and POLICY OF CARE

For patients without dental insurance, full payment for professional services is expected at the time of treatment.

If you are covered by insurance, any deductible and co-payment will be due on the day of your appointment. Insurance is a contract between YOU and your insurance company. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. It is your responsibility to monitor your benefits and annual maximum. You agree to pay any portion of the charges not covered by insurance.

For your convenience, we offer the following payment options:

- Cash;
- Check;
- Credit (Visa, MasterCard, Discover);
- We also offer interest free or extended payment plans through **CareCredit®** dental financing (based on approved credit). Please ask if you would like more information.

Please give us at least 24 hours' notice if it is necessary to change an appointment. If an appointment is not kept, it is our policy to charge a fee of $50.00 for each half hour scheduled.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that 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 that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

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. 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.

I have received, read and understand your Notice of Privacy Practices containing a more completed description of the uses and disclosures of my health information. I have also read and understand the Financial Agreement and Policy of Care and understand that this organization has the right to change any document from time to time. I am aware that I may contact this organization at any time to obtain a current copy of the Notice of Private Practices, Financial Agreement and/or Policy of Care.

Signature____ **Date**________________________

If at any time you have a question or are unhappy about any treatment, fee or service, please tell us. We want our patients to be satisfied with the care and service we provide. "Treat others the same way you would want to be treated". For us, this golden rule will always remain the highest priority.