

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Name (Last) _____ (First) _____ (M) _____ (Preferred) _____

Address _____ City _____ State _____ Zip _____

(Street Address if PO Box)

Home Phone _____ Cell # _____ E-mail _____

Check Appropriate Box: Minor Single Married Divorced Widowed Separated

Employer _____ Work Phone _____

Sex Male Female Age _____ Date of Birth _____ Social Security # _____

If Patient is a Student, Name of School/College _____ City _____ State _____

General Dentist _____ Specialist _____

Has a family member been to our office? _____

PARENT/GUARDIAN INFORMATION

Name _____ Relationship to Patient _____

Address (if different from above) _____ Home Phone _____

Employer _____ Work Phone _____

Date of Birth _____ Social Security # _____

PRIMARY INSURANCE INFORMATION

Name of Insured _____ Relationship to Patient _____

Date of Birth _____ Social Security # _____

Employer _____ Work Phone _____

Insurance Company _____ Subscriber # _____ Group # _____

Claims Address _____ City _____ State _____ Zip _____

ADDITIONAL INSURANCE INFORMATION

Name of Insured _____ Relationship to Patient _____

Date of Birth _____ Social Security # _____

Employer _____ Work Phone _____

Insurance Company _____ Subscriber # _____ Group # _____

Claims Address _____ City _____ State _____ Zip _____

PAYMENT AND INSURANCE NOTICE

Payment is due at the time that services are rendered. If other financial arrangements are necessary, they must be made prior to surgical treatment. Any partially paid balances are due and payable within 30 days from the date of services. Interest shall accrue on unpaid balances after the due date at the rate of sixteen percent (16%) per annum, until paid in full.

As a courtesy to you, we will file insurance claims directly with your insurance company, unless your plan requests otherwise. In order to do so, we must have accurate information regarding your insurance coverage. Payment of services rendered remains your responsibility, but we will be glad to assist you in obtaining reimbursement from your insurance carrier.

Increasing delinquency in payment of accounts has made it necessary to obtain written consent to guarantee of payment and/or financial responsibility of all accounts. In the event that it is necessary to refer your account to an attorney or collection agency for collection, the undersigned hereby agrees to pay, in addition to the balance due on the account, plus interest as set forth above, all of our costs of collection, including reasonable attorney's fees, collection agency fees, and expenses of collection, including but not limited to court filing and service fees.

I hereby authorize Drs. Bailey, Peoples & Oghalai, P.A. to furnish information to my insurance company concerning my care. I further hereby assign all payments for services rendered to Dr. Bailey and/or Dr. Peoples and/or Dr. Oghalai. I understand that I am financially responsible for all services rendered.

I have read the above information and hereby acknowledge receipt of a copy of information and agree to terms stated herein.

DATE _____

SIGNATURE _____

(i.e. LEGAL GUARDIAN OR SELF-FINANCIAL RESPONSIBILITY)

WITNESS _____

SOCIAL SECURITY # _____

OVER

Patient's Name _____

MEDICAL HISTORY INFORMATION

HAVE YOU EVER HAD:

Yes No

- Abnormal Heart Condition
 Heart Murmur
 Rheumatic Fever
 Bleeding Condition
 High Blood Pressure
 Diabetes
 Emphysema
 Liver Disease
 Fainting or Black Out Spells
 Asthma
 Depression
 Chemotherapy or IV Drug Treatment
(i.e. Aredia, Bonefos, Zometa) for cancer
(i.e. Breast, Prostrate)
 Radiation
 Osteoporosis Medicine
(Fosamax, Actonel, Boniva, Didronel, Skelid)

Yes No **Infectious Disease**

- Hepatitis
 HIV (Aids Virus)
 Tuberculosis (TB)

Allergies

- Penicillin
 Mycin Drugs
 Latex
 Local Anesthetic (Numbing)
 Other _____

(Women)

- Are you pregnant now?
How far along _____
 Are you currently Nursing?

Physician's Name _____ Phone _____

Have you had any serious illnesses or operations? _____ Yes _____ No

If yes, describe _____

Present Medications _____

Do You Have Any Other Information You Think We Should Know About?

PRIVACY NOTICE

Drs. Bailey, Peoples & Oghalai, P.A. understands that your medical information is personal to you, and we are committed to protecting the information about you. As our patient, we create medical records about your health, our care for you, and the services and/or items we provide to you as our patient. By law, we are required to make sure that your protected health information is kept private. Examples of how we may use or disclose your information is as follows: to obtain payment for our services, in emergency situations, for appointment and patient recall reminders, to avert a serious threat to health or safety, for workers compensation programs, in response to certain requests arising out of lawsuits or other disputes, etc. If you feel your rights have been violated, you may file written complaint with the practice by contacting our office manager. You will not be penalized for filing a complaint. You also have rights regarding the information we maintain about you. These include the right to inspect and copy, amend, and request restrictions.

By signing below, I acknowledge that I have read and answered the questions above to the best of my knowledge. I also acknowledge that I have been presented a copy of Drs. Bailey, Peoples & Oghalai, P.A. Privacy Notice.

Date _____

Signature _____

(Legal Guardian If patient is a minor)