PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

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

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:

Section 3

Physician`s Name

Emergency Contact #

Emergency Contact

Pharmacy #

Pharmacy Name

Physician`s Number

previous dentist

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: Rem. Deduct:

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: Rem. Deduct:

Stephanie L. Skinner, D.M.D.

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

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, c

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

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

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 WeightLoss	◯ 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 Problems	◯ 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 If yes

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:

X Date:_____

Stephanie L. Skinner D.M.D.
Family Dentistry

Financial Policy

The following is a statement of our Financial Policy for services provided within our office and do not apply to any testing, diagnostic procedures performed outside of this practice or referrals to any specialist. We require you to read and sign this document prior to treatment in our office.

Patient Responsibility

Due to insurance regulations, co-pays are due at time of service. If there is no insurance, balance is due at time of service. All professional services rendered are charged to the patient and are due at time of service. As a courtesy, this practice will file your claim with your insurance carrier, however, the patient or responsible party is ultimately responsible for the charges not covered by your contract with the carrier. If the claim is not paid within 45 days, the balance becomes the responsibility of the patient.
Insurance carriers typically do not cover all dental costs. Some pay fixed allowances for each procedure and office visit while others pay a percentage of the cost. It is the patient's responsibility to understand their insurance coverage.

When you receive a statement, you are requested to pay the balance in full upon receipt. If for some reason you do not agree with the balance amount due, you are requested to contact a billing representative at the phone number noted on the statement. Do not ignore the bill as it may result in turning the balance over to an outside collection agency for recovery.

Since we are not a credit company, we do not extend credit. If you need credit for charges in the future, you may apply for credit from an outside agency / credit card company. We accept all major credit cards, debit cards, cash and check.

I understand that I am financially responsible to the practice of Stephanie L. Skinner D.M.D.

I understand that if my account becomes past due and has to be turned over to a 3rd party collection agency, there will be a collection fee of 35% added to my balance.

Assignment of Benefits

I hereby assign and authorize my insurance benefits to be paid directly to Stephanie L. Skinner D.M.D.

Print Name *Signature of Patient / Responsible Party*

Date: _____

Stephanie L. Skinner D.M.D.
Family Dentistry

10515 White Bluff Rd.
Savannah, Ga. 31406
912-925-6613
Email: skinnerdmd@comcast.net

Records & X-Ray Release Form

Patient Name: _____

Patient Date of Birth: _____

Dear Dr. Skinner,

I hereby authorize you to release any information or records regarding my dental treatment to Dr. Skinner's office. Please send any x-rays or any other information that would be helpful with my dental treatment.

Thank You,

_____

Patient's / Parent's / Guardian's Signature Date

Stephanie L. Skinner D.M.D.
Family Dentistry

Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy of this offices Notice of Privacy Practices

Print Name: _____ Date: _____

Sign Name: _____

Consent for Use and Disclosure of Health Information

Signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and health operations.

You have the right to revoke this consent at time by giving us written notice of your revocation submitted to the contact person listed on our Notice of Privacy Practice Sheet. Please understand that revocation of this consent will affect any action we took in relevance on this consent before we received your revocation and that we may decline to treat you if you revoke this consent.

I've had full opportunity to read and consider the contents of this consent form. I understand that by signing this form, I am giving my consent to use and disclose my health information to carry out treatment, payment activities and health care operations.

Print Name: _____ Date: _____

Sign Name: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices and Consent for use and disclosure of health information, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other : _____

Stephanie L. Skinner D.M.D.
Family Dentistry
10515 White Bluff Rd.
Savannah, Ga. 31406
(912)925-6613

PHOTOGRAPHY RELEASE

I ----------, herby consent and authorize the doctors and staff of Stephanie L. Skinner Family Dentistry to take photographs, slides and/or videos of my face, jaws and teeth.

I understand that the photographs, slides and/or videos will be used as a record of my care and may be used without my given name or with a fictitious name for educational purposes in lectures, demonstrations, advertising, professional publications (dental magazines and journals) and any other lawful purpose.

I release and forever discharge the doctors and staff of Stephanie L. Skinner Family Dentistry from any claim, demands or liability on account of such use or for the quality of reproduction.

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Signature Date

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Witness Date