ADULT REGISTRATION

Date _____

Patient Name _____

Name you wish to be addressed by _____

Mailing Address _____ City _____ State _____ Zip _____

Street Address (if different) _____

Telephone _____ Birthdate _____ SS# _____

Marital Status: _____ Single _____ Married _____ Divorced _____ Separated _____ Widowed

Spouse Name (if applicable) _____

Your Employer _____ Work Phone _____

Spouse's Employer _____ Work Phone _____

Name you wish this account placed in _____

Address (if different) _____

In case of an emergency, please list the name of a friend or relative whose telephone number is different than yours.

Name _____ Relationship _____

Address _____ Telephone _____

Who may we thank for referring you to our office? _____

DENTAL INSURANCE INFORMATION

Dental Insurance #1

Policyholder _____ Birthdate _____

Employer _____ SS# _____

Insurance Company Name _____

Policy # _____ Group # _____

Dental Insurance #2

Policyholder _____ Birthdate _____

Employer _____ SS# _____

Insurance Company Name _____

Policy # _____ Group # _____

Our office policy is to accept payment at the time services are rendered unless arrangements are made in the front office in advance. We file your dental insurance as a courtesy to you. You are ultimately responsible for payment for all your dental care.

I authorize the release of any information necessary to process my insurance claim.

X _____

I hereby authorize payment directly to the dentist of the insurance benefits otherwise payable to me. A copy of this signature is as valid as the original.

X _____

I understand and agree that any credit granted shall be paid promptly in accordance with terms and agreements, that the credit grantor may add one and one half percent (1.5%) per month to any balance owed after ninety (90) days, and in the event of default to pay reasonable collection charges and/or attorney fees.

X _____

Health History

MEDICAL HISTORY

Patient's Name_____

Physician's Name_____ Date of last physical exam_____

Do you have or have you had any of the following: Please indicate with check mark (✓).

___Any heart problems
___High blood Pressure
___Low blood Pressure
___Circulatory problems
___Nervous problems
___Radiation treatments
___Excessive bleeding
___AIDS
___Asthma
___Diabetes
___Hepatitis
___Herpes
___Malignancies
___Measles
___Mumps
___Rheumatic Fever
___Sinus Problems
___Stroke
___Tuberculosis
___Ulcer
___Venereal Disease
___Anemia
___Arthritis
___Other

Are you Pregnant____

Are you allergic to medicines or drugs?_____

Are you allergic to anesthetics?
_____

Are you currently taking blood thinners (i.e. Coumadin, aspirin)_____
Do you have artificial: pins, plates, valves, or joints? _____ If yes, do you need to take pre medication before teeth cleanings or extractions? _____

Please list all medications you are currently taking: (if you have a current list, we can make a copy)

_____
_____
_____

Please describe any current medical or dental treatment and impending operations:

_____
_____
_____

Date _____ Your Signature _____

DENTAL HISTORY

Are you having any discomfort at this time _____
How long since you have been to a dentist _____
What was done then _____
_____
Did you have X-rays _____
Have you lost any teeth _____
Why_____
Any complications with extractions_____
Are your teeth sensitive: to heat_____ to cold_____
to sweets_____ to sour_____

How often do you brush your teeth_____
When_____
Do you use dental floss_____ How often_____
Do you have bleeding gums_____

Have you had your teeth straightened_____
When_____

Do you grind or clench your teeth_____
When_____
Do you feel you have bad breath at times_____
Unpleasant taste in mouth_____
Are you aware of any swelling or lump in your mouth_____
Do you have any fear of having dentistry done_____
If yes, why_____
Do you want to avoid denture's_____
Do you want to know how you can keep the natural teeth you still have_____
If you have children, do you want to learn how they may keep their natural teeth for a lifetime without discomfort_____

PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day-to-day healthcare operations of your practice

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this day _____ of _____, 20___.

Print Patient Name: _____

Relationship to patient (if applicable): _____

Signature: _____

Bryan T. Stump, DMD – Family Dentistry
1642 US 131 South
Petoskey, MI 49770

Payment Policy

Insurance Acceptance Guidelines:

The following is a list of insurance companies we are in Network (participate) with:
Cigna & Delta Dental both include Medicare Advantage plans.

We are out of network with all other insurances. As a courtesy to the patient we will bill all insurance policies that are out of network.

The patient is responsible for all co-insurance and deductibles.

All self-pay patients are expected to pay date of service.

Unpaid balances:

Any unpaid balances on your account past 90 days (from the time insurance pays) will result in a monthly finance charge of 1.5% of your total balance until balance is paid in full.

We can take credit/debit card payments over the phone.

No Show Appointments:

1st missed/no show appointment- No charge, we understand life happens.
2nd missed/no show appointment- $35 non reimbursable charge.

We classify a missed/no show appointment as being an appointment where there is not enough time to fill the appointment with another patient in need of services. If we are able to fill your appointment no charge will be filed. A 5-minute notice is not enough time to fill your appointment.

We give a courtesy call within 48 hours to all of our patients personally, leave messages to confirm, and you most likely have an appointment card. **Please call us back to confirm your appointment!** If you think you have an appointment but did not receive a phone call within 48 hours of this appointment please call us.

Please sign this form below to acknowledge that you have read over all of our policies.
Thank you!

_____ _____

Patient Signature/Parent or Guardian Signature Date

_____

Patient Printed Full Name

Bryan T. Stump, DMD
Robert O. Pemberton, DDS
1642 US 131 South
Petoskey, MI 49770