PATIENT REGISTRATION

Date: _____ Date of Birth: _____

Patient Name _____ SS #: _____

☐ Male ☐ Female

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

Home Address Street: _____

City: _____ State: _____ Zip: _____

Phone Numbers Home: ( ) _____ Business: ( ) _____

Mobile: ( ) _____ Email: _____

Employer _____

If patient is a minor, who is legally responsible? _____

SS# _____ DOB _____

In case of emergency, who should we contact? _____

Phone: ( ) _____ Relationship: _____

Referred by: _____

Method of Payment: ☐ Cash ☐ Check ☐ Visa or Mastercard

INSURANCE INFORMATION

Is treatment covered by insurance? ☐ Yes ☐ No

Name of Insurance Company _____ Phone:( ) _____

Insurance Address: _____

Subscriber's Name: _____ SS#: _____

Date of Birth: _____ Patient's Relationship to Subscriber: _____

Subscriber's Employer: _____ Group or Policy Number: _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Name of Secondary Insurance Company _____ Phone: ( ) _____

Insurance Address: _____

Subscriber's Name: _____ SS#: _____

Date of Birth:: _____ Patient's Relationship to Subscriber: _____

Subscriber's Employer: _____ Group or Policy Number: _____

I hereby authorize payment of the dental and insurance benefits and authorize the release of dental information to my insurance company in order for claims to be processed. I have received the financial agreement for insurance.

_____

Patient or Guardian Signature

PATIENT MEDICAL HISTORY

Patient Name (please print) _____ Date _____
Physician _____ Office Phone _____ Date of Last Physical Exam _____
Are you under medical treatment now?_____ Have you been in the last 2 years? _____
Have you ever been hospitalized for any surgery or serious illness? _____
Do you have or have you had any of the following conditions? Please check all that apply.

Heart Attack/Surgery	Hepatitis/Jaundice	Arthritis
Heart Murmur	Kidney Disease	Glaucoma
Heart Disease/pacemaker	Diabetes	Fainting
Chest Pains	Thyroid Problems	Epilepsy/Convulsions
High/Low Blood Pressure	Stomach Problems	HIV Infection/Aids
Rheumatic Fever	Leukemia/Anemia/blood disorder	Herpes Simplex Ior II
Stroke	Cancer	Drug Addiction
Asthma/Respiratory	Radiation/Chemotherapy	I have taken Fen-Phen
Hay Fever/Allergies	Tuberculosis	Do you wear contacts
Full/partial Joint Replacement	Other _____	

Please list any disease, condition or problem not listed _____

Women only:
Are you pregnant?_____ Are you taking birth control? _____
Are you aware that antibiotics can decrease the effectiveness of birth control? _____

MEDICATIONS

Please list medications you are currently taking:
_____
_____
_____
____ Not currently taking meds
Pharmacy Name: _____

ALLERGIES

Have you had a reaction to any of the following? (Please check if yes)

Aspirin/Ibuprofen____		Penicillin	____
Codeine	____	Sedatives	____
Iodine	____	Sulfa	____
Latex	____	Local Anesthetic	____
No known drug allergies ____		Other _____	

PATIENT DENTAL HISTORY

When was your last dental visit? _____ For what reason? _____
Who was your previous dentist? _____ When were x-rays last taken? _____

Yes	No		Yes	No	
____	____	Are you having pain/discomfort at this time?	____	____	Have you had any problems with your jaw?
____	____	Do your gums bleed when you brush?	____	____	Do you clench or grind your teeth?
____	____	Do you have a history of gum disease?	____	____	Do you wear a denture, partial or retainer?
____	____	Have you had difficult extractions in the past?	____	____	Have you had a bad experience in dental ofc
____	____	Do you have any lumps in/near your mouth?	____	____	Do you use tobacco products?
____	____	Have you had any head, neck or jaw injuries?	____	____	Do you like your SMILE?

Signature I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information may be detrimental to my health.

Patient Signature_____ Parent or Guardian _____

Doctor Signature _____ Date _____

Financial Policy

Thank you for choosing Wellpoint Dental as your dental care provider! Our professional dental team is committed to providing you excellent dental care in a friendly, comfortable setting. The following is a statement of our financial policy, which we request that you read and sign prior to treatment.

Full payment is due at the time of service. We accept cash, check, debit cards, Visa, MasterCard, Discover, American Express, and Care Credit. Interest on balances unpaid beyond 90 days will be applied at the rate of 1.5% monthly (18% annually). *While we do accept assignment of insurance benefits, your portion of each service is due at the time services are rendered. This may be based on an estimate of insurance payment.*

Your insurance policy is a contract between you, your employer and your insurance company. We are not a party to that contract. We do, however, submit dental claims as a courtesy to our patients and will do our best to assist you in understanding and applying your dental benefits. *We cannot guarantee insurance payments or payment amounts. All treatment estimates are provided based upon information from your insurance company and are estimates only.* If your insurance company has not paid your account in full within 90 days of billing, we will require the balance to be paid directly by you via cash, check, debit or credit card.

Treatment plans are created based upon clinical findings during your diagnostic exam and are subject to change based upon clinical need and/or our treatment schedule.

Our policy is to charge for missed appointments, or appointments that are cancelled less than a 24 hour notice at the rate of $25.00 per appointment. Please help us serve you better by keeping scheduled appointments.

Returned checks are subject to an additional fee of $25.00. Unpaid balances are subject to action by a collection agency.

Signature on File

By signing below, I give my permission for Wellpoint Dental to release necessary information regarding my treatment to my insurance company(s) and assign dental benefit payments directly to Wellpoint Dental.

If you have any further questions regarding our financial policy, please ask a member of our dental team.

I UNDERSTAND AND AGREE TO COMPLY WITH THIS FINANCIAL POLICY.

Printed Name: _____ **Date:** _____

Signature:_____

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DENTAL

NOTICE OF PRIVACY PRACTICE

This notice describes how medical information about you may be used and disclosed. It also explains how to obtain access to this information. Please review it carefully.

The Health Information Portability and Accountability Act of 1996 (HIPPA) requires all health care records and other individually identifiable health information used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPPA provides penalties for covered entities that misuse personal information. As required by HIPPA, we have prepared this explanation of how we are required to maintain the privacy of the health information and how we may use and disclose your health information. Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. For example, we may need to share information with other providers or specialists involved in the continuation of your care.
Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization reviews. For example, we disclose treatment information when billing insurance for your treatment.
Health Care Operations include the business aspects of running our practice. For example, patient information may be used for training purposes, or quality assessment.

Unless you request otherwise, we may use or disclose health information to a family member, friend or other personal representative to the extent necessary to help with your healthcare or with payment for your healthcare. In addition, we may use your confidential information to remind you of appointments by sending postcards and/or leaving messages at home/work. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization. You have certain rights in regards to your protected health information, which you can exercise by presenting a written request to our Privacy Office at the practice address listed below.
The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are however not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless y you agree in writing to remove it. The right to request to received confidential communications of protected health information from us by alternative or at alternative locations. The right to access, inspect, and copy your protected health information. You have the right to request an amendment to your protected health information. The right to receive an accounting of disclosures of protected health information outside of treatment, payment and health care operations. The right to obtain a paper copy of this notice from us upon request. We are required by law to maintain the privacy of your health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of **April 15, 2003** and we are required to abide by the terms of this Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revises Notice from this office. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health and Human Services Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, please contact:

Steven L Payne D.M.D.
2700 W Cherry Ln Ste 120
Meridian, Idaho 83642

For more information about HIPPA or to file a complaint:

US Department of Health & Human Services
Office of Civil Rights
200 Independence Ave, S.W.
Washington, DC 20201
(877)696-6775 (toll free)

WELL POINT DENTAL GROUP

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

(Please check one of the following)

*I have received a copy of this office's notice of Privacy Practices _____

*I have reviewed the notice of Privacy Practices, but declined my copy _____

Please print name

Signature Date

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
- Communication barriers prohibited obtaining acknowledgment
- An emergency situation prevented us from obtaining acknowledgment
- Other (please specify)_____
  _____

wellpoint
DENTAL

2700 W Cherry Ln., Ste. 120 · Meridian, ID · 83642

RECORD RELEASE REQUEST

Please release my dental records:

Name: _____

Address: _____

_____

Date of Birth: _____

From Previous Dental Office : _____

Address: _____

_____

Phone: _____ Fax: _____

To: Wellpoint Dental

Address: 2700 W Cherry Lane Ste 120

Meridian, ID 83642

Phone: 208-887-9000

Signature: _____

Date: _____