TIME 02:30 PM

PATIENT REGISTRATION

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Responsible Party is also a Policy Holder for Patient Primary Insurance Policy Holder Secondary Insurance Policy Holder Patient Information Address 2: Patient Information Address: State / Zip: Pager: Home Phone: State / Zip: Pager: Home Phone: Work Phone: Ext: Collutar: Sex: Male Female Marital Status: Marined Single Divorced Separated Widowed Birth Date: Age: Soc Sec: Drivers Lie: Female Section 3 Carrier ID: Perf. Dentist: Employment Full Time Part Time Relationship to Insured: Self Other Name of Insured: Pref. Planmacy: Employment Employment Child Other Name of Insured: Pref. Planmacy: Imsured Hirth Date: Employment Child Other Name of Insured: Relationship to Insured: Self Spouse Child Other Insured Soc Sec: Insured Hirth Date: City, State, Zip: City, State, Z	Home Phone:	Work Phone:			Ext:	Cellular:
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Address:	Responsible Party is also a	Policy Holder for Patient	Primary Insurance	Policy Holder		Secondary Insurance Policy Holder
City:	——— Patient Information —					
Home Phone: Ext: Cellular: Sex: Male Female Marital Status: Married Single Divorced Separated Widowed Birth Date: Age: Soc Sec: Drivers Lic: Drivers Lic: <tdd< td=""><td>Address:</td><td></td><td>Address</td><td>s 2:</td><td></td><td></td></tdd<>	Address:		Address	s 2:		
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Birth Date: Age: Soc Sec: Drivers Lis: E-mail: I would like to receive correspondences via e-mail. Section 2 Section 3 Section 2 Section 3 Employment Status: Full Time Part Time Student Status: Full Time Part Time Medicaid ID: Prof. Dentist: Emergency Contact # Employer ID: Prof. Pharmacy: Emergency Contact # Carrier ID: Prof. Harmacy: Emergency Contact # Name of Insured: Relationship to Insured: Socues Insured Soc. Sec: Insured Birth Date: City, State, Zip: Kem. Benefits: Rem. Deduct: City, State, Zip: City, State, Zip: Name of Insured: Rem. Deduct: Socues City of the spouse Child Other Insured Soc. Sec: Insured Socie Secies Insured Socies Socues City, State, Zip: City, State, Zip: City State, Zip: City, State, Zip: City of the spouse Child Other Insured Soc. Sec: Insured Socies Insured Socies Socies Socies City, State, Zip: City of the spouse Child </td <td>Home Phone:</td> <td>Work Phone:</td> <td></td> <td></td> <td>Ext:</td> <td>Cellular:</td>	Home Phone:	Work Phone:			Ext:	Cellular:
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Date Created:

Date 4/13/2020

Have you ver had a serious head or nex injury? O'res Orto H'ryse Arayou taking any medications, pills, or drugs? O'res Orto H'ryse Do you takks, or have you taken, Plan-Fe or Reduc? O'res Orto H'ryse Do you takks, or have you taken, Plan-Fe or Reduc? O'res Orto H'ryse Arayou taking any medications, painting high bond provides of the series of the	ave you ever been berni				0.00	() No	If yes					
Are you taking any medications, pills, or drugs? 'res Ne 'ryes Do you taking any medications, pills, or drugs? 'res Ne 'ryes Have you ever taken Foreames, Bonins, Actionel or any other 'res Ne 'ryes Are you are taken foreames, Bonins, Actionel or any other 'res Ne Do you use bocks? 'res Ne 'ryes 'ryes	ave you ever been nospi	Have you ever been hospitalized or had a major operation?			() Yes	() No	If yes					
Do you take, or have you taken, Phen-Feh or Redux? Ves No If yes Have you ever taken Posamas, Boniva, Actonel or any other Redications octating bisphophages? Are you on a special diet? Ves No Do you use tobacco? No Do you use tobacco? Ves No Do you use tobacco? No Do you use tobacco? Ves No Do you use tobacco? Interesting to the following? Pregnant/Trying to get pregnant? Norming? Applinin Previous of the following? Applinin Ves No Athemiat Ves No Athemiat Ves No Athemiat Ves No Anemia Second Ves No Athemiat Ves No Frequent Cough Ves No No Athemiat Ves No Athemiat Ves No Frequent Cough Ves No No Athemiat Ves No Athemiat Ves No Frequent Cough Ves No No Athemiat Ves No Athemiat Ves No Athemiat Ves No Athemiat Ves No Frequent Cough Ves No No Athemiat Ves No Athemiat V	łave you ever had a seric	us head o	or neck in	jury?	() Yes	() No	If yes					
Have you ever taken Posamas, Boniva, Actorel or any other medications constanting Displayabounds? Nary you on a pool of the Solowing? Pregramet/Trying to get pregnent? Pregramet/Trying to get pregnet/Trying to get pregnent	reyou taking any medica	tions, pill	s, or drug	ıs?	() Yes		If yes					
medications containing bisplondee?	o you take, or have you	taken, Phe	en-Fen or	Redux?	() Yes	⊖ No	If yes					
Do you use tobacco? Yes No If yes Do you use controlled substances? Yes No If yes Impained Trying to get pregnent? Aspin Impained Trying to get pregnent? Aspin Impained Trying to get pregnent? Abplint Positive Yes No If yes Impained Trying to get pregnent? Impained Trying to get pregnent? Abplint Positive Yes No If yes Impained Trying to get pregnent? Impained Trying to get pregnent? Abplint Positive Yes No Contisone Median Yes No Hemophila Yes No Rediction Treetments Yes				el or any other	() Yes	O No	If yes					
Do you use controlled substances? Yes No If yes Inter: Are you	re you on a special diet?				() Yes	O №						
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Pregnant/Trying to get pregnant? IMursing? Imaking oral contraceptives? Pregnant/Trying to get pregnant? Penicillin Codeine Acrylic Aspirin Penicillin Codeine Acrylic Metal Latex Sulfa Drugs Local Anesthetics Other? If yes If yes If yes applying to get pregnant? Other? Other? If yes applying to get pregnant? Other? Other? If yes applying to get pregnant? Other? Other? If yes applying to get pregnant? Other? No Relation Treatments Yes Alzheimer's Disease Yes No Diabetes Yes No Heapathisa A Yes No Recent WeightLoss Yes Anemia Yes No Easily Winded Yes No Heapathisa Yes No Recent WeightLoss Yes No Anthritis/Gout Yes No Easily Winded Yes No Heapathisa Yes No Scale Cell Disease Yes No Scale Cell Disease Yes	o you use controlled sub	stances?			() Yes	O №	If yes					
e you allergic to any of the following? Acpuira Acpuira Acpuira Acpuira Acpuira Acpuira Acpuira	men: Are you											
Appirin Penicillin Codeine Acrylic Metal Latex Sulf a Drugs Local Anesthetics Other? If yes Local Anesthetics Yes you have, or have you had, any of the following? Cortisone Mediane Yes No Radiation Treatments Yes Albheimer's Disease Yes No Cortisone Mediane Yes No Recent Weight Loss Yes Anenhia Yes No Drug Addiction Yes No Heapatitis A Yes No Recent Weight Loss Yes Anenhia Yes No Drug Addiction Yes No Heapatitis B or C Yes No Recent Weight Loss Yes No Anenhia Yes No Enpilysema Yes No Heapatitis B or C Yes No Recent Weight Loss Yes No Arthritis/Goat Yes No Enpilysema Yes No High Cholesterol Yes No Scarlet Fever Yes Yes No Scarlet Fever Yes No Arthridial Joint Yes <td>Pregnant/Trying to get</td> <td>pregnant</td> <td>?</td> <td></td> <td>Nursi</td> <td>ng?</td> <td></td> <td></td> <td>Taking ora</td> <td>I contraceptives?</td> <td></td> <td></td>	Pregnant/Trying to get	pregnant	?		Nursi	ng?			Taking ora	I contraceptives?		
Metal		following?										
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a you have, or have you had, any of the following? AIDS/HIV Positive \res \No Cortisone Medidine \Yes \No Hemphilia \Yes \No Radiation Treatments \Yes \ Albeimer's Disease \Yes \No Diabetes \Yes \No Diabetes \Yes \No Hepatitis A \Yes \No Hepatitis A \Yes \No Recent WeightLoss \Yes \Yes \ Anaphylads \Yes \No Drug Addiction \Yes \No Hepatitis B or C \Yes \No Real Dialysis \Yes \Yes \ Anamia \Yes \No Easily Winded \Yes \No Hepatitis B or C \Yes \No Remain Dialysis \Yes \Yes \Yes \No Addiction \Yes \No Hepatitis B or C \Yes \No Remain \Yes \No Reumatic Fever \Yes \Yes \Addiction \Yes \No Easily Winded \Yes \No Hepatitis B or C \Yes \No Reumatic Fever \Yes \Yes \Addiction \Yes \No Easily Winded \Yes \No Hepatitis B or C \Yes \No Reumatic Fever \Yes \Yes \Addiction \Yes \No Easily Winded \Yes \No High Blood Pressure \Yes \No Scarlet Fever \Yes \Yes \Addiction \Yes \No Excessive Bleeding \Yes \No High Cholesterol \Yes \No Scarlet Fever \Yes \Yes \Addiction \Yes \No Excessive Thirst \Yes \No Excessive Thirst \Yes \No High Phylogiycenia \Yes \No Sickle Cell Disease \Yes \Yes \Yes \No Singles \Yes \Yes \Yes \No Elledong \Yes \Yes \No Frequent Cough \Yes \Yes \No Irregular Heartbeat \Yes \No Sinus Trouble \Yes \Yes \Yes \No Sinus Trouble \Yes \Yes \Yes \No Elledong \Yes \No Frequent Cough \Yes \No Leve \No Leve \No Leve \No Sinus Trouble \Yes \Yes \Yes \Yes \No Elledong \Yes \No Erequent \Yes \No Frequent Headaches \Yes \No Low Blood Pressue \Yes \No Sinus Trouble \Yes \Yes \Yes \Yes \No Carter \Yes \No Erequent Adverted \Yes \No Leve \No Leve \No Leve \No Leve \No Erequent \Yes \No Hay Fever \Yes \No Hay Fever \Yes \No Advected \Yes \No Hay Ever \Yes \No Heart Advect/Intestinal Disease \Yes \No Carter \Yes \No Heart Advect/Allure \Yes \No Pain in Jaw Joints \Yes \No Uere \Yes \No Heart Advect/Allure \Yes \No Pain \Yes \No Erequent Xellor \Yes \No Heart Advections \Yes \No Carter \Yes \No Heart Advections \Yes \No H	Metal			Latex				Sulfa Drugs		Local Anesthetics		
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Asthma Yes No Fainting Spells/Dizziness Yes No Irregular Heartbeat Yes No Sinus Trouble Yes O Blood Disease Yes No Frequent Cough Yes No Kidney Problems Yes No Spina Bifida Yes O Blood Transfusion Yes No Frequent Diarrhea Yes No Leukemia Yes No Stomach/Intestinal Disease Yes O Breathing Problems Yes No Frequent Headaches Yes No Leukemia Yes No Stomach/Intestinal Disease Yes O Bruise Easily Yes No Genital Herpes Yes No Low Blood Pressure Yes No Swelling of Limbs Yes O Cancer Yes No Glaucoma Yes No Lung Disease Yes No Tonsillitis Yes O Chemotherapy Yes No Haart Attack/Failure Yes No Osteoporosis Yes No Tumors or Growths Yes Yes O	Artificial Heart Valve	⊖ Yes	ONo	Excessive Blee	ding	⊖ Yes	() No	Hives or Rash	OYes ONo	Shingles	() Yes	0
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Bruise Easily Yes No Genital Herpes Yes No Low Blood Pressure Yes No Swelling of Limbs Yes O Cancer Yes No Glaucoma Yes No Low Blood Pressure Yes No Thyroid Disease Yes O Chemotherapy Yes No Hay Fever Yes No Mitral Valve Prolapse Yes No Tonsillitis Yes O Chemotherapy Yes No Heart Attack/Failure Yes No Osteoporosis Yes No Tuberculosis Yes O Cold Sores/Fever Blisters Yes No Heart Murmur Yes No Pain in Jaw Joints Yes No Tumors or Growths Yes O Congenital Heart Disorder Yes No Heart Pacemaker Yes No Parathyroid Disease Yes No Venereal Disease Yes O Convulsions Yes No Heart Trouble/Disease Yes No Yes Yes Yes Yes Yellow Jaundice Yes Yes <td>Blood Transfusion</td> <td>() Yes</td> <td>ONo</td> <td>Frequent Diarrh</td> <td>ea</td> <td>() Yes</td> <td>O No</td> <td>Leukemia</td> <td>O Yes O No</td> <td>Stomach/Intestinal Disease</td> <td>() Yes</td> <td>0</td>	Blood Transfusion	() Yes	ONo	Frequent Diarrh	ea	() Yes	O No	Leukemia	O Yes O No	Stomach/Intestinal Disease	() Yes	0
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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:



INSURANCE POLICY

Our practice is committed to providing the best treatment possible for our patients! Mission Dental accepts many insurance plans and we are in network with most companies.

So, what does this mean for you? As a patient who participates in an insurance plan through your place of employment or Marketplace, it is important to know and understand that your insurance plan is a contract between the insurance company, your employer, and you.

Because we are honored to have you as a patient, we are committed to doing the hard part for you! It is our policy to VERIFY your coverage and **ESTIMATE** your out-of-pocket expenses before treating you. Please be mindful that these are just estimates. There are times your insurance company may pay LESS than promised, and times they may pay more than promised. Your insurance company ultimately gets to decide what they will or will not pay once the claim is submitted.

As a courtesy, our team will submit a single claim, up to two times for you. If payment from your insurance company is not received within 60 days of treatment, you are then responsible for the remaining balance.

All **ESTIMATED** out-of-pocket investments are due at the time of your reservation. I understand and agree that I will be responsible for any patient portion or account balance that remains unpaid by me, or my insurance carrier after 60 days. In the case of default of payment, I promise to pay all accrued finance charges, interest, and administrative fees on the balance due, together with any collection costs and attorney's fees incurred in order to collect on this account.

I, ______ (print name), have received a copy of Mission Dental's Insurance Policy.

Signature

Date



RESERVATION POLICY

It is our goal to render excellent dental care to our patients. To be consistent with this, we have a **Reservation Policy** that allows us to maintain integrity in seeing our patients in a timely manner. When chair-time is reserved, we set aside a specific amount of time to give our patients our undivided attention. When a reservation is cancelled with less than a 48-hour notice, it does not provide ample time to modify the schedule. **Our policy is as follows:**

We require that you give our office a **48-hour** notice if you need to reschedule your reservation. This will allow other patients to reserve that time, if needed. If you miss a reservation without contacting our office within the required time, that is considered a missed reservation. As a courtesy, the first missed reservation will only serve as a reminder that any future missed reservation will incur a fee of \$75.00. This fee cannot be billed to your insurance company. Additionally, records cannot be transferred without payment of this fee.

In some cases, it may be necessary to reschedule patients who are more than 15 minutes late without notice. This is also considered a missed reservation and the same fee of \$75.00 will be incurred after the first courtesy.

If you have any questions regarding this policy, please do not hesitate to ask our team! We thank you for your patronage.

I have read and understand the Reservation Cancellation Policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

I, ______ (print name), have received a copy of Mission Dental's Reservation-Cancellation Policy.



ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

You may refuse to sign this acknowledgement

I, ______, have received a copy of this offices Notice of Privacy Practices.

(Signature of Patient or Guardian)

(Date)

AUTHORIZATION OF RELEASE OF INFORMATION

Purpose: This form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself.

I, ______, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

(Please Print Name)

(Relationship)

(Please Print Name)

(Relationship)

(Please Print Name)

(Relationship)



PATIENT PHOTO RELEASE FORM

I, _______, hereby authorize Mission Dental, or any of their assignees to take photographs, slides, and videos of my teeth, jaws, and face. I understand that the photographs, slides, and videos will be used as a record of my care, and may be used for communication with other health care professionals, educational publications (dental journals), and educational lectures. The content may also be used for advertising purposes (including website publication, facebook posts, etc).

I further understand that if the photographs, slides, and videos are used in any publication or as a part of a demonstration, my identifying information (first name only) could be used unless stated differently below. I do not expect compensation, financial or otherwise, for the use of these photographs. If I wish to revoke this consent, I may do so in writing.

If declining this consent, please leave blank.

Please initial one option:

_____I do not mind if my photographs are used in any of the above stated situations.

_____I only agree to have my teeth shown without any identifying features.

Signed_____

Date