Patient Registration

First Name:____________________Last Name:____________________Middle Initial:_____ Gender______ Pronoun___

Date of Birth:___________________Age:__________If Child: Parent's Name:____________________________________

Address:____City, State, Zip:______________________________________

Home Phone:_____________________Cell Phone:______________________Work Phone:_______________________

Email:______________________________________

Emergency Contact Name:________________________Emergency Contact Phone Number:_______________________

Parent/Patient Employed By:_________________________Present Position:___________________________________

Spouse/Parent Name:___________________________Spouse Employed By:__________________________________

Present Position:________________________

Who is responsible for this account:___________________________

Method of Payment: ◯ Insurance ◯ Cash ◯ Credit Card

Other Family Members in this Practice:____

Patient/Parent Social Security Number:_____________________Spouse/Parent Social Security No._________________

Whom may we thank for this referral:________________________How did you hear about us:_________________

Primary Insurance Information:

Name of Insured:_________________________Date of Birth:_____________Relationship to patient_________________

Employer Name__________________________________Name of Insurance Co.________________________________

Insurance Co. Address____Ins. Co. Phone_____________________

ID #:_______________________Group #:_______________________Social Security No._______________________

Secondary Insurance Information:

Name of Insured_________________________Date of Birth_____________Relationship to Patient_________________

Employer Name___________________________________Name of Insurance Co._______________________________

Insurance Co. Address____Ins. Co Phone_______________________

ID#:______________________Group #:________________________Social Security No.________________________

CONSENT: I consent to the necessary treatment recommended by the dentist for dental care and for the dentist to use and disclose my records (child records) to perform treatment. I consent to the release of my records (child records) to individuals involved in my care (child's care) or payment for that care. My consent to the disclosure of my records (child records) shall be effective until I terminate it in writing. I understand that my dental insurance carrier may not pay the full amount of the actual bill for services completed and that I am responsible for payment in full of all accounts. By signing this I agree to be responsible to pay for services completed and not paid by my dental care payer. I consent that the information on this form is accurate and current.

Patient/Guardian Signature____Date:_____________________

Payment Agreement

In exchange for services rendered by Woodbury Family Dentists (WFD)

1. My Responsibilities. I understand that insurance is estimated and the actual coverage may be less than estimated. I, the patient (or responsible party if patient is minor), am responsible for payment of all amounts not covered by my insurance carrier, regardless of the estimate, I also understand that it is my own responsibility to know or to determine what my insurance plan covers and does not cover, including deductibles and yearly/lifetime maximum amounts.
2. Payment Due at Time of Service. Unless, at the time of receiving dental services, I present evidence of dental insurance currently in effect. I understand that payment is due in full at the time of service, unless other arrangements are made in advance. WFD offers a 5% discount for payment made on the date of service.
3. 90-Day Payment Terms. If l cannot pay at the time of service and if l arrange in advance to be billed for services performed, I understand that WFD offers payment at no interest for up to 90 days. The balance must be paid in full within 90 days by cash, check, major credit card, or CareCredit financing.
4. Referral to Collections. After 90 days, and outstanding balances of any amount will be turned over for collections pursuant to the laws of the State of Minnesota. I agree to pay all reasonable attorney fees, disbursements,' and collection fees incurred by WFD in an effort to collect past due payments on my account.
5. Option to Use Care Credit. In any of two circumstances, (1) if l cannot pay at the time of service: or (2) if I have made arrangements to pay within 90 Days but cannot do so, I understand that I also have the option to pay through CareCredit, and independent organization that will pay WFD in full and that may provide me with small, extended monthly payments. I may obtain information about CareCredit directly from WFD. I am responsible to work with CareCredit to obtain credit through that organization.
6. My Consent. I hereby understand that failure to sign this Payment Agreement does not negate my financial responsibility to pay for any services that have been rendered: By accepting dental services or treatment, of any type, I am giving my consent o the terms as outlined in this Payment Agreement.
7. My Understanding of These Terms. I have read, understand, and agree to all of the above. I also understand that I may have a full accounting of all payments to my account simply by asking.
8. Written Modifications Only. This Agreement may not be modified except in a writing signed by WFD.

Patient Signature____Date ________________________

Parent (or Responsible Party)_______________________________Relationship to Patient _______________

Cancellation/Failed Appointment Policy

Our office policy requires that you notify us of any change in plans 48 hours prior to your reserved appointment(s). This permits another patient to receive dental care in your absence. Because we do not schedule several patients at the same time, all appointments are reserved exclusively for you. Patients who fail to show or do not cancel 48 hours in advance will be subject to a $50 fee.

I have read and understand the information provided above.

Name____ Date:_________________

Woodbury Family Dentists

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Name:_______________________________ Phone Number:___________________________

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and health care operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practice as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practice, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, include any revisions of our notice, at any time by contacting us at:

Telephone: (651) 731-8424 **Fax:** (651) 731-0917
Address: 8325 City Center Drive- Suite 125, Woodbury MN 55125

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, _______________________________ have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature:______________________________ Date:_____________________

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Representative's Name:______________________ Relationship to patient:________________

Request for designated others to have access to Account Information

I, ______________________ authorize Woodbury Family Dentists to disclose my account information with regard to scheduling and billing information to the following designated people:

___________________________ _________________ ____________
Print Full Name Relationship Phone number

I understand I may revoke this authorization by sending a written request for revocation to Woodbury Family Dentists. I understand when Woodbury Family Dentists discloses this information pursuant to this authorization the information may no longer be protected by federal or state privacy rules and may be subject to re-disclosure by the recipient of the information. I understand and agree to the terms of the authorization.
Signature: ____________________________________ Date:_________________________

American Dental Association
www.ada.org

Child Health/Dental History Form

Patient's Name ____ LAST ____ FIRST ____ INITIAL | Nickname ____ | Date of Birth ____

Parent's/Guardian's Name ____ | Relationship to Patient ____

Address ____ PO OR MAILING ADDRESS ____ CITY ____ STATE ____ ZIP CODE

Phone ____ Home ____ Work | Sex M ❑ F ❑

Have you (the parent/guardian) or the patient had any of the following diseases or problems? ❑ Yes ❑ No
1. Active Tuberculosis, 2. Persistent cough greater than a three-week duration, 3.Cough that produces blood?
If you answer yes to any of the three items above, please stop and return this form to the receptionist.

Has the child had any history of, or conditions related to, any of the following:

❑ Anemia
❑ Arthritis
❑ Asthma
❑ Bladder
❑ Bleeding disorders
❑ Bones/Joints
❑ Cancer
❑ Cerebral Palsy
❑ Chicken Pox
❑ Chronic Sinusitis
❑ Diabetes
❑ Ear Aches
❑ Epilepsy
❑ Fainting
❑ Growth Problems
❑ Hearing
❑ Heart
❑ Hepatitis
❑ HIV +/AIDS
❑ Immunizations
❑ Kidney
❑ Latex allergy
❑ Liver
❑ Measles
❑ Mononucleosis
❑ Mumps
❑ Pregnancy (teens)
❑ Rheumatic fever
❑ Seizures
❑ Sickle cell
❑ Thyroid
❑ Tobacco/Drug Use
❑ Tuberculosis
❑ Venereal Disease
❑ Other____________

Please list the name and phone number of the child's physician:

Name of Physician ____________________ Phone ____________

Child's History

	Yes	No
1. Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? If yes, please list: ____	❑	❑
2. Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: ____	❑	❑
3. Is the child allergic to anything else, such as certain foods? If yes, please explain: ____	❑	❑
4. How would you describe the child's eating habits? ____		
5. Has the child ever had a serious illness? If yes, when: ____ Please describe: ____	❑	❑
6. Has the child ever been hospitalized?	❑	❑
7. Does the child have a history of any other illnesses? If yes, please list: ____	❑	❑
8. Has the child ever received a general anesthetic?	❑	❑
9. Does the child have any inherited problems?	❑	❑
10. Does the child have any speech difficulties?	❑	❑
11. Has the child ever had a blood transfusion?	❑	❑
12. Is the child physically, mentally, or emotionally impaired?	❑	❑
13. Does the child experience excessive bleeding when cut?	❑	❑
14. Is the child currently being treated for any illnesses?	❑	❑
15. Is this the child's first visit to a dentist? If not the first visit, what was the date of the last dentist visit? Date: ____	❑	❑
16. Has the child had any problem with dental treatment in the past?	❑	❑
17. Has the child ever had dental radiographs (x-rays) exposed?	❑	❑
18. Has the child ever suffered any injuries to the mouth, head or teeth?	❑	❑
19. Has the child had any problems with the eruption or shedding of teeth?	❑	❑
20. Has the child had any orthodontic treatment?	❑	❑
21. What type of water does your child drink? ❑ City water ❑ Well water ❑ Bottled water ❑ Filtered water		
22. Does the child take fluoride supplements?	❑	❑
23. Is fluoride toothpaste used?	❑	❑
24. How many times are the child's teeth brushed per day? ____ When are the teeth brushed? ____	❑	❑
25. Does the child suck his/her thumb, fingers or pacifier?	❑	❑
26. At what age did the child stop bottle feeding? Age ____ Breast feeding? Age ____		
27. Does child participate in active recreational activities?	❑	❑

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Parent's/Guardian's Signature ____________________ Date ____________

For completion by dentist
Comments ____________________

For Office Use Only: ❑ Medical Alert ❑ Premedication ❑ Allergies ❑ Anesthesia Reviewed by____________
Date ____________

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Form S707

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