PATIENT REGISTRATION

Personal Information

Name_____Preferred Name_____

Birthday_____ SS#_____ Gender: [ ] M [ ] F Married: [ ] Y [ ]N

Home (_____)_____ Wireless (_____)_____

Work (_____)_____

Email Address _____

Home Address_____

Preferred Contact Method [ ]Hm Phone [ ]Wk Phone [ ]Wireless Phone [ ]Email

Preferred Confirmation Method [ ]Hm Phone [ ]Wk Phone [ ]Wireless Phone [ ]Email

Student Status if dependent over 18 [ ]Non Student [ ]Full Time [ ]Part Time

How did you hear about **Brookhaven Dental Group**?_____

Insurance Information

Your Relationship to the subscriber: [ ]Self [ ]Spouse [ ]Child

Subscriber Name_____Subscriber ID_____

Subscriber SS#_____ Subscriber Employer_____

Insurance Company_____ Phone #_____

Group Name_____ Group #_____

Please present insurance card to receptionist.

MEDICAL HISTORY

Name of physician: _____

Phone/address: _____

Have there been any changes to your health in the past year? _____

Have you ever had to be pre-medicated before having dental work? Y N

If so, for what reason(s): _____

Have you ever had any serious illnesses/operations or hospitalizations within the past five (5) years?

If so, describe: _____

Women: are you pregnant? Y N Nursing? Y N Taking birth control? Y N

*Please initial: "I understand that taking antibiotic may cause contraceptives to be ineffective"_____

Please check (✓) any of the following conditions that apply:

ABNORMAL BLEEDING		CANCER/CHEMOTHERAPY		GLAUCOMA		HIGH BLOOD PRESSURE	
ALCOHOL/DRUG ABUSE		COLITIS		HEART ATTACK		HIV/AIDS	
ALLERGIES		CONGENITAL HEART DEFECT		HEART MURMUR		INFLAMMATORY RHEUMATISM	
ANEMIA		DIABETES		HEART PACEMAKER		KIDNEY PROBLEMS	
ARTHRITIS		EMPHYSEMA		HEART SURGERY		LIVER DISEASE	
ARTIFICIAL BONE/JOINT		EPILEPSY		HEMOPHILIA		LOW BLOOD PRESSURE	
ASTHMA		FAINTING/DIZZY SPELLS		HEPATITIS		LUPUS	
BLOOD TRANSFUSION		FREQUENT HEADACHES		HERPES/BLISTERS		MITRAL VALVE PROLAPSE	

MEDICAL HISTORY CON'T

PSYCHIATRIC PROBLEMS		SEIZURES		SINUS PROBLEMS		TUBERCULOSIS	
RADIATION TREATMENT		SHINGLES		STROKE		STOMACH ULCERS	
RHEUMATIC/SCARLET FEVER		SICKLE CELL		THYROID PROBLEMS		VENEREAL DISEASE(S)	

Please list any disease, condition, or diagnosis that was not previously listed: _____

Please list all current medications: _____

Please indicate (✓) any allergies to the following:

ASPIRIN		CODEINE		DENTAL ANESTHETIC		ERYTHROMYCIN	
LATEX		PENICILLIN		SULFA		TETRACYCLINE	

If yes, please describe your reaction: _____

_____

All questions have been answered truthfully and to the best of my knowledge.

Patient Signature _____ Date_____

HIPAA ACKNOWLEDGEMENT OF RECEIPT
Notice of Privacy Practices

Patient's Name:_____ D.O.B. _____

We at **Brookhaven Dental Group** are required by law to maintain the privacy of and provide individuals with the attached notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to the notice, please ask to speak with our HIPAA Compliance Officer in person or by phone at 404-549-2650. If you would like a copy of the notice please feel free to ask.

I hereby acknowledge that I have reviewed the HIPAA Notice of Privacy Practice document.

_____ _____
Signature of patient or patient's representative Date

_____ _____
Printed name of patient or patient's representative Relationship to patient

INSURANCE POLICIES

Our practice is committed to providing the best treatment possible for our patients! **Brookhaven Dental Group** *participates* with insurances, and we are in network with most. So what does this mean for you?

As a patient who participates in an insurance plan through your place of employment or the 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 my credit card will be charged for any patient portion or account balance that remains unpaid by either 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 have read, understand, and agree with the above policy.

Patient Signature _____ Date _____

AUTHORIZATION FOR CREDIT CARD PAYMENTS (CREDIT CARD ON FILE)

I, _____, understand that I have chosen to assign my dental benefits to **Brookhaven Dental Group** and claim form(s) will be sent to my insurance company for treatment provided, and/or I am entering into a financial arrangement with the office to pay for my dental treatment.

I further realize that I am ultimately responsible for the cost of treatment regardless of my insurance company's willingness to pay a benefit.

I hereby authorize **Brookhaven Dental Group** to keep my signature on file and to charge my credit card account for any and all treatment fees not paid by my insurance carrier or myself within 60 days or in agreement with the terms/dates of my financial arrangement.

NOTE: We will make every effort possible to notify you in advance of your authorized card being charged for an amount greater than $100.00.

_____ Cardholder's Address 1

_____ Cardholder's Address2

_____ Cardholder's Telephone #

MasterCard Visa AMEX Discover

Credit Card Account # _____

Exp Date and CVV2 _____

Cardholder's Signature_____ Date _____

RESERVATION POLICY

It is our goal to render excellent dental care to our patients. In an attempt 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. Therefore, when a patient is late, that time is then limited, and forces our team to squeeze in as much as we can, to be on time for our next scheduled reservation. If a reservation is canceled 24 hours or less, it does not provide us ample amount of time to schedule another patient in that reserved chair. With this said, **Our policy is as follows:**

We require that you give our office **48 hours** notice in the event that you need to reschedule your reservation. This allows for other patients to reserve that chair, if needed. If you miss a reservation without contacting our office within the required time, this is considered a missed reservation. As a courtesy, the first missed reservation will only be a reminder that the next missed reservation will incur a fee of $75.00. This fee cannot be billed to your insurance company. Unfortunately, no future reservations can be scheduled, nor can records be transferred without payment of this fee.

Additionally, patients more than 15 minutes late without notice, will be considered a missed reservation and will incur the same fee of $75.00 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 **Brookhaven Dental Group's** Reservation Cancellation Policy.

_____ _____

Signature of Patient Date