Maple Leaf Implant and General Dentistry ***New Patient Registration Form***

Welcome to Maple Leaf

GENERAL INFORMATION **(PLEASE CLEARLY PRINT)**

Patient Name: _____
Last **First** **MI** **Preferred Name**

___Male ___Female ___Married ___Single ___Child ___Other

Birth Date:_____ SS#: _____ State DL#: _____

Email Address: _____ Best time to call: _____

Phone: (H):_____ (C):_____ (Wk):_____ (Ext):_____

Address 1:_____ Address 2:_____

City:_____ State:_____ Zip: _____

PATIENT EMPLOYMENT INFORMATION

Employer Name:_____ Phone:_____

Employer Address 1 :_____ Address 2:_____

City: _____ State:_____ Zip: _____

RESPONSIBLE PARTY INFORMATION

This only needs to be filled out if the insured subscriber is other than patient, parent or guardian of patient.

The following is for: __patient's spouse __parent __guardian __other

Name:_____ __Male ___Female

__Married ___Single __Child __Other Birth Date:_____ SS#_____

DL# & State:_____ Email:_____

Address 1:_____ Address 2: _____

City:_____ State:_____ Zip:_____

Responsible Party Employer Name:_____ Phone: _____

PRIMARY DENTAL INSURANCE

Name of Insured:_____
Last First MI

Insured's Birth Date:_____ ID#_____ Group#_____

Insured's Address 1: _____ Address 2:_____

City: _____ State:_____ Zip: _____

Patient's relationship to insured: __Self __Spouse __Child __Other

Insured's Employer Name & Address:_____

Address: _____ City: _____ State_____ Zip:_____

Insured's Employer Phone#: _____

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DENTAL INSURANCE INFORMATION CONTINUED

Insurance Plan Name & Address:_____

Address:_____ City:_____ State:_____ Zip:_____

Phone including area code: _____

***By signing below, I authorize my insurance company to pay the dentist all insurance benefits rendered. I authorize the use of an electronic signature on all insurance submissions. I authorize the dentist to release all information necessary to secure payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.**

****Signature:***_____ ***Date:*** _____

DENTAL INFORMATION

How would you rate the condition of your mouth? __Excellent __Good __Fair __Poor

Please provide previous dentist name and phone:_____

Date of most recent dental exam and dental x-rays:_____

I routinely see my dentist: __3 mo. __4 mo. __6 mo. __12 mo. __Not routinely

What is your immediate concern?: _____

Is there anything about your smile that you would like to change?: _____

_____

Check all that apply:

__Complications from past dental treatment
__Trouble getting numb
__Reaction to local anesthesia
__Had/have braces, orthodontic treatment
__Experience dry mouth
__Teeth are sensitive to hot, cold, biting, sweets or avoid brushing any part of the mouth
__Food trapped between teeth
__Whitened or bleached teeth
__Difficulty chewing
__Clench or Grind teeth
__Wear or have worn bite appliance
__Gums bleed when brushing or flossing
__Treated for gum disease or told you have bone loss around your teeth
__Noticed unpleasant taste or odor in your mouth
__Experience gum recession
__Teeth become loose without injury
__Burning sensation in your mouth
__Snore or wake up frequently during the night

***By signing this registration form, I acknowledge that I have reviewed and answered ALL questions/alerts to the best of my knowledge.**

****Signature:***_____ ***Date:***_____

Maple Leaf Implant and General Dentistry ***New Patient Registration Form***

Please READ ALL Financial Policy and Hipaa Alerts and COMPLETE AND *SIGN Patient Representative Authorization Form on following pages. Thank you for choosing Maple Leaf Implant & General Dentistry for your dental needs.

Patient Representative Authorization Form

(HIPAA Acknowledgement)

I understand that I may inspect or copy the protected health information described by this authorization and may receive a copy of this practice's Notice of Privacy Practices upon request. I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and payment for my healthcare will not be affected if I refuse to sign this form. I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

***Please sign** and list below anyone whom you authorize to have access to your records. Indicate if each patient representative may have access to health/financial information. We will release record to anyone that you list as your representative. A minor may not be listed as a patient representative. Both parents must be listed as a minor's patient representative unless a court documentation is presented restricting access of parent(s).

Patient Name:_____ Birth Date:_____

1.Name:_____

Relationship to patient:_____

___Health Information ___Financial Information

2. Name:_____

Relationship to patient:_____

___Health Information ___Financial Information

3. Name:_____

Relationship to patient:_____

___Health Information ___Financial Information

Signature of patient or parent/guardian:**_____ ***Date:_____

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CONSENT FOR SERVICES AND FINANCIAL POLICY

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment. All Emergency Dental Services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time of services performed unless other arrangements are made. Patients with dental insurance understand that all dental services are charged directly to the patient and that he/she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be pain by an insurance company. A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination. In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. ***I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment. By signing the above information and agree to its contents.**

****Signature:*** _____ ***Date:*** _____

CONSENT FOR INTERNET COMMUNICATIONS

I grant permission to the dental practice to upload and store confidential patient information (including account, appointment, and clinical information) to the secured web site for the dental practice. I understand, for security purposes, the site requires a user ID and password for access and use. I also understand, the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will at all times during the terms of this agreement and thereafter, comply with all laws directly or indirectly applicable that may nor or hereafter govern the persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. **I understand the dental practice CANNOT and DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES. *By signing the above information regarding the secured uploading of patient information to the website for the dental practice and grant the dental practice permission to securely upload my patient information to the web site.**

****Signature:*** _____ ***Date:*** _____