# PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder Preferred Name:
☐ Responsible Party

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

◯ Responsible Party is also a Policy Holder for Patient ◯ Primary Insurance Policy Holder ◯ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ◯ Male ◯ Female Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed

Birth Date: Age: Soc. Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ◯ Full Time ◯ Part Time ◯ Retired

Student Status: ◯ Full Time ◯ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg.:

Section 3

Additional Comments:

Primary Insurance Information

Name of Insured: Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City,State,Zip: City,State,Zip:

Rem. Benefits: .00 Rem. Deduct: .00

Secondary Insurance Information

Name of Insured: Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City,State,Zip: City,State,Zip:

Rem. Benefits: .00 Rem. Deduct: .00

Dr. Steven Muha

# MEDICAL HISTORY

FOR

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____

Are you on a special diet? ◯ Yes ◯ No _____

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Women: Are you

Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

| | | | |
|---|---|---|---|
| AIDS/HIV Positive ◯ Yes ◯ No | Cortisone Medicine ◯ Yes ◯ No | Hemophilia ◯ Yes ◯ No | Renal Dialysis ◯ Yes ◯ No |
| Alzheimer's Disease ◯ Yes ◯ No | Diabetes ◯ Yes ◯ No | Hepatitis A ◯ Yes ◯ No | Rheumatic Fever ◯ Yes ◯ No |
| Anaphylaxis ◯ Yes ◯ No | Drug Addiction ◯ Yes ◯ No | Hepatitis B or C ◯ Yes ◯ No | Rheumatism ◯ Yes ◯ No |
| Anemia ◯ Yes ◯ No | Easily Winded ◯ Yes ◯ No | Herpes ◯ Yes ◯ No | Scarlet Fever ◯ Yes ◯ No |
| Angina ◯ Yes ◯ No | Emphysema ◯ Yes ◯ No | High Blood Pressure ◯ Yes ◯ No | Shingles ◯ Yes ◯ No |
| Arthritis/Gout ◯ Yes ◯ No | Epilepsy or Seizures ◯ Yes ◯ No | Hives or Rash ◯ Yes ◯ No | Sickle Cell Disease ◯ Yes ◯ No |
| Artificial Heart Valve ◯ Yes ◯ No | Excessive Bleeding ◯ Yes ◯ No | Hypoglycemia ◯ Yes ◯ No | Sinus Trouble ◯ Yes ◯ No |
| Artificial Joint ◯ Yes ◯ No | Excessive Thirst ◯ Yes ◯ No | Irregular Heartbeat ◯ Yes ◯ No | Spina Bifida ◯ Yes ◯ No |
| Asthma ◯ Yes ◯ No | Fainting Spells/Dizziness ◯ Yes ◯ No | Kidney Problems ◯ Yes ◯ No | Stomach/Intestinal Disease ◯ Yes ◯ No |
| Blood Disease ◯ Yes ◯ No | Frequent Cough ◯ Yes ◯ No | Leukemia ◯ Yes ◯ No | Stroke ◯ Yes ◯ No |
| Blood Transfusion ◯ Yes ◯ No | Frequent Diarrhea ◯ Yes ◯ No | Liver Disease ◯ Yes ◯ No | Swelling of Limbs ◯ Yes ◯ No |
| Breathing Problem ◯ Yes ◯ No | Frequent Headaches ◯ Yes ◯ No | Low Blood Pressure ◯ Yes ◯ No | Thyroid Disease ◯ Yes ◯ No |
| Bruise Easily ◯ Yes ◯ No | Genital Herpes ◯ Yes ◯ No | Lung Disease ◯ Yes ◯ No | Tonsillitis ◯ Yes ◯ No |
| Cancer ◯ Yes ◯ No | Glaucoma ◯ Yes ◯ No | Mitral Valve Prolapse ◯ Yes ◯ No | Tuberculosis ◯ Yes ◯ No |
| Chemotherapy ◯ Yes ◯ No | Hay Fever ◯ Yes ◯ No | Pain in Jaw Joints ◯ Yes ◯ No | Tumors or Growths ◯ Yes ◯ No |
| Chest Pains ◯ Yes ◯ No | Heart Attack/Failure ◯ Yes ◯ No | Parathyroid Disease ◯ Yes ◯ No | Ulcers ◯ Yes ◯ No |
| Cold Sores/Fever Blisters ◯ Yes ◯ No | Heart Murmur ◯ Yes ◯ No | Psychiatric Care ◯ Yes ◯ No | Venereal Disease ◯ Yes ◯ No |
| Congenital Heart Disorder ◯ Yes ◯ No | Heart Pace Maker ◯ Yes ◯ No | Radiation Treatments ◯ Yes ◯ No | Yellow Jaundice ◯ Yes ◯ No |
| Convulsions ◯ Yes ◯ No | Heart Trouble/Disease ◯ Yes ◯ No | Recent Weight Loss ◯ Yes ◯ No | |

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: _____

Comments: _____

_____

_____

_____

_____

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 _____ DATE _____

# Cancellation Policy

As of June 1, 2009 all appointments must be canceled at least 24 hours before scheduled appointment time to allow other patients needing appointments the opportunity to be seen. Patients with appointments not cancelled within the allotted time will be charged a fee of $25 per appointment cancelled. No-show appointments will be handled in the same manner.

We understand that emergencies occur and we will be happy to reschedule your appointment when necessary. In order to assist our patients, reminders and confirmations are sent early enough (by postcard or e-mail) in case a cancellation is needed.

We appreciate your thoughtfulness and consideration in this matter. Thank you for your cooperation.

Please sign and date below that you have read and understand our policy on cancelled/no show appointments.

Signature:_____ Date:_____

# About Financial Arrangements and Dental Insurance

We are committed to providing you with the best possible care. If you have dental or medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need you assistance and your understanding of our payment policy.

Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. We accept cash, checks, Master Card, Visa, or up to 12 Months no interest financing with Citi Health Card. We will be happy to help you process your insurance claim form for your reimbursement. In special instances we may accept assignment of insurance benefits.

**You may realize, however, that:**

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore, are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50% or 80%) of U.C. R. "U.C.R." is defined as usual, customary, and responsible fees for this region. Thus, our fees are considered usual, customary, and reasonable by most companies.

   *This statement does not apply to companies who reimburse based on arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.*

3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. Whatever is not paid within 30 days, you are liable for and any balance due is to be payable in full.

We must emphasize that as dental care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all changes are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE do not hesitate to ask us. We are here to help you.

Signature_____ Date_____