HAWK RIDGE DENTAL CARE

Patient Registration

First_______________________________M.I.:____ Last__________________________Preferred Name __________________________

Street: ____City: _______________________ State:_________ Zip: _______________

Home #: (_______)_______________Cell #: (_______)_______________Email :____

Sex: M F Date of Birth:_________________ Age:_________ Social Security No.:__________________________________

Employer:____ Marital Status: Married Divorced Legally Separated Widow Single

How did you hear about us? Friend or Family Referral Website Mailer Sign 1-800-Dentist

Who will be responsible for your account? Self Spouse Parent Other

Name:_______________________________________ Date of Birth: __________________Phone #: (_______) _____________________

Street:_______________________________________ City:________________________ State:________ Zip:____________________

*Please present your Dental Insurance card upon your first visit. If no insurance is being utilized, please check here ☐

Would you like to know more about payment arrangements or financing options? Y N Would you like to know more about our in house membership plan, HSP? Y N

Primary Insurance Information

Relation to Patient: Self Spouse Parent Other

Policy Holder's Name :_____________________________________ Date of Birth:____/___/____ Employer:_____________________________

ID or SS Num :____Group No:____

Insurance Co. ____ Insurance Co Phone #: _____________________________________

Secondary Insurance Information

Relation to Patient: Self Spouse Parent Other

Policy Holder's Name :_____________________________________ Date of Birth:____/___/____ Employer:_____________________________

ID or SS Num :____Group No:____

Insurance Co. ____ Insurance Co. Phone #_____________________________________

Authorization of Dental Insurance Benefits

Please remember that dental insurance is considered a method of deferred payment and is not a substitution for payment. It is your responsibility to pay any deductible amount, co-insurance, or any other balance deemed patient responsibility by the insurance company. It is your responsibility to pay the balance in full if the insurance information you provide us proves false or otherwise ineffective. It is your responsibility to follow all guidelines of your insurance company. Information regarding any change in your insurance coverage must be provided prior to receiving service. To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's record. This Assignment will remain in effect until revoked by me in writing. A signed photocopy of the Assignment is to be considered as valid as an original.

I request that payment of authorized dental benefits be made on my behalf to Michael and Angela Pernoud, DDS, PC or Hawk Ridge Dental Care for any services provided. I authorize the release of any dental information needed to determine the benefits payable for related services. I authorize the release of all dental information necessary to process insurance claims and hereby assign and authorize direct payment of all dental benefits to the undersigned: **Michael and Angela Pernoud, DDS, PC Hawk Ridge Dental Care, Lake St. Louis, MO**

✖ **Patient's or Legal Guardian's Signature ____Date ______________**

Authorization of Personal Health Information (HIPAA and Notice of Privacy Practices)

We will not discuss any dental or financial information with anyone except the patient or legal guardian unless named on this form.
This release may be rescinded at any time in writing. We cannot guarantee your request will be honored to the fullest.
Please list family or friends that we may discuss your dental treatment with. *Example: Spouse, Grandparent, Child's Caregiver)*

Name of Person	Relationship to Patient

If you would like us to not to speak with anyone regarding your dental treatment please check here ☐

I give permission to Hawk Ridge Dental Care to release information (verbal or written) regarding dental treatment to the above named person for only the purpose of dental management.

I have been given or reviewed Hawk Ridge Dental Care's Notice of Privacy Practices

From time to time in caring for our patients, it may be necessary to contact patients by phone or email. When you are not available for us to speak to directly, we like to leave messages where possible
In order to protect your privacy, we have developed a policy on leaving messages. We will attempt to, as a courtesy, leave a reminder message regarding an upcoming appointment. *Via email, text or voice mail*

✖ **Patient's or Legal Guardian's Signature ____Date ______________**

Hawk Ridge Dental Care's Financial Policies

PAYMENT OF SERVICES RENDERED:

- The patient's estimated payment portion will be collected at the time of service.
- For non-insured patients, full payment is due for the service(s) rendered at the time of treatment unless otherwise arranged.
- This office is not a party for divorce decrees or most other 3rd party agreements. Adult patients are responsible for their portion at the time of service. The responsibility for minors rests with the accompanying adult.

DENTAL BENEFITS:

- Your dental benefit plan is a contract between you and your provider. Due to the nature of dental benefit plans, there may be additional out of pocket expenses you will be responsible for paying despite the level of stated coverage by your benefit carrier.

- As a courtesy, we will attempt to check your insurance status at your initial visit or when you provide us new insurance information. However, it is the benefit holder's responsibility to know his/her own plan, limitations, coverage status, etc. and represent this as truthfully as possible to the best of his/her knowledge. You must inform us of any changes in your coverage. If a service is provided and your coverage has lapsed or changed, you may be subjected to any applicable late charges starting from the date of service.
- Based on the information your benefit carrier is willing to provide, we will estimate what amount may be covered for treatment. Because individual plans greatly vary in their scope of coverage and carriers will not always provide complete information (such as, but not limited to, fee schedules, limitations, frequency of coverage, etc.) many times it is impossible to make a perfect estimate. We will collect the estimated portion of payment at the time of treatment. We cannot and will not assume any responsibility for the actual level of coverage you receive from your benefit company. You are ultimately responsible for the entire fee regardless of any estimate of coverage provided.
- We will submit benefit claims for the patient unless other arrangements are made. We allow sixty days (60) to process benefit claims before collecting the remainder of the full fee from the patient. After this point in time, you may be subjected to late fees for non-prompt payment. If and when your carrier makes a final payment, you will be refunded any difference. We recommend that you follow up with your insurance company after thirty (30) days of non-payment to ensure that your insurance company pays promptly. For larger treatment plans, we may require an alternate payment method be in place before treatment. Please call us if you need assistance in this matter.

LATE FEES:

- There is a $33.00 fee for any returned checks. In addition, any other costs incurred by our office will be added to your account. Once added, this fee cannot be removed.
- A late fee of $33.00 per month will be applied to any account if the balance is unpaid for 30 days after the service has been rendered or 90 days after submission to insurance. Once added, this fee cannot be removed.
- For any balance that is overdue and legal and/or collection assistance is necessary for the collection of the account, the responsible party will be liable for the fees incurred. All collection accounts are also subject to interest charges as allowed by law.

RESERVING APPOINTMENTS FOR RESTORATIVE CARE OR PERIODONTIAL CARE:

- In order to reserve your appointment, ten percent (10%) of your treatment fee will be collected at the time of scheduling.

- This payment is non-refundable if an appointment is canceled or rescheduled with less than 48 business hours notice.

- Upon completion of the scheduled appointment, the prepaid portion will be deducted from your estimated patient portion. If there is not a patient portion due at the time of service, the collected amount will be refunded .

I have read and understand Hawk Ridge Dental Care's Financial Policies

______________________________ ______________________

Patient/Legal Guardian **Date**

Hawk Ridge Dental Care's Health History

To Our Patients: Your health is of the utmost importance to us. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the care that you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.

Name____ DOB:________________ Height___________ Weight______________

Physician's Name: ____ Physician's #: (_______) ____________________________

Are you under the care of a physician? Y N If so, what are you being treated for?______________________________________

MEDICATIONS Are you taking any kind of medicine, drug, or pills for any purpose? Y N

Are you taking…..

Anticoagulants (Blood Thinners)	Y	N
Tranquilizers	Y	N
Cortisone	Y	N
Bisphosphonates – used to treat osteoporosis and similar diseases	Y	N
Antibiotics—Currently taking? If yes, which one?	Y	N

Other Medications (Please list with dosage and purpose) *If you have a list of medications we will make a copy for your chart*

____ ____

____ ____

____ ____

ALLERGIES

Are you allergic to or had a reaction to: Please Circle

Local anesthetics	Y	N
Latex	Y	N
Penicillin	Y	N
Other antibiotics	Y	N
Sulfa Drugs	Y	N
Barbiturates, Sedatives, or Sleeping Pills	Y	N
Aspirin	Y	N
Iodine	Y	N
Codeine or Other Narcotics	Y	N
Other Medications	Y	N
Allergies Other than Drug Allergies. Please List:	Y	N

WOMEN

Is there a possibility that you may be pregnant? Estimated delivery date?_____________________	Y	N
Are you nursing?	Y	N
Are you on any form of birth control?	Y	

Medical History is continued on the back.

HAVE YOU HAD OR DO YOU HAVE……..

Rheumatic Fever	Y	N	Arthritis or Joint Disease	Y	N
Damaged Heart Valve/Mitral Valve Prolapse	Y	N	Joint Replacement	Y	N
Heart Murmur	Y	N	Osteoporosis	Y	N
Irregular Heart Beat	Y	N	Stomach Ulcers	Y	N
Chest Pain/Angina	Y	N	Gallbladder Trouble	Y	N
Heart Attack(s)	Y	N	Thyroid Trouble	Y	N
Stroke	Y	N	Fainting Spells	Y	N
Cardiac Pacemaker	Y	N	Convulsions/Epilepsy	Y	N
High Blood Pressure	Y	N	Eye Diseases/Glaucoma	Y	N
Low Blood Pressure	Y	N	Pain and/or Clicking of Jaws	Y	N
Heart Surgery	Y	N	Contagious Diseases	Y	N
Bronchitis/Chronic Cough	Y	N	Sexually Transmitted Diseases	Y	N
Asthma	Y	N	AIDS or HIV Infection	Y	N
Hay Fever/Sinus Problems	Y	N	Problems of the Immune System	Y	N
Tuberculosis	Y	N	Infectious Mononucleosis	Y	N
Emphysema	Y	N	Radiation Treatment/Chemotherapy	Y	N
Difficulty Breathing	Y	N	Cancer	Y	N
Any Other Lung Problems	Y	N	A Tumor or Growth	Y	N
Blood Disorders (i.e. Anemia)	Y	N	Malignant Hyperthermia	Y	N
Bruise Easily	Y	N	Swollen Ankles	Y	N
Abnormal Bleeding Tendency	Y	N	Do You Use Tobacco?	Y	N
Jaundice, Hepatitis, or Liver Disease	Y	N	Do You Drink Alcoholic Beverages?	Y	N
Blood Transfusion	Y	N	Do You Use Recreational Drugs?	Y	N
Diabetes	Y	N	Are You on a Diet?	Y	N
Low Blood Sugar	Y	N	Mental Health Problems?	Y	N
Kidney Trouble	Y	N			
Are You on Dialysis	Y	N	Any other conditions or surgeries? Please List	Y	N

____

____

To the best of my knowledge, the above medical information is accurate.

✖ ____ ________________

Signature of Patient/Parent or Legal Guardian **Date**

Dental Health History

Name: ______________________________ Date:________________________

Please answer the following questions about your dental health:

- What is your main concern today?

  ____

- What is your goal for today's visit?

  ____

Do you suffer from, or been told that you have any of the following: Circle Yes or No

Pain on biting	Y	N	Headaches/Migraines	Y	N
Sensitivity to hot/cold	Y	N	Clenching/Grinding	Y	N
Sensitivity to sweets	Y	N	Snoring	Y	N
Gum disease	Y	N	Restless sleep	Y	N
Jaw pain, neck pain, TMD	Y	N	Dry mouth	Y	N
Yellow teeth	Y	N	Bad breath	Y	N
Dental anxiety	Y	N	Bad bite/Malocclusion	Y	N

How would you rate your smile on a scale of 1-10: _____

What would you like to change with your smile?_____________________________________

______________________________________*Office Use*________________________________

____

____

____

B/P_________________

1. (C)	L	M	H	______________________________
2. (P)	L	M	H	______________________________
3. (O)	L	M	H	______________________________