



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

Referred By:

Previous Dentist:

Emergency Contact:

Emergency Contact #:

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



MEDICAL HISTORY

Philip W.S. Park DDS.

PATIENT NAME _____ Birth Date _____

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?
Have you ever been hospitalized or had a major operation?
Have you ever had a serious head or neck injury?
Are you taking any medications, pills, or drugs?
Do you take, or have you taken, Phen-Fen or Redux?
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?
Are you on a special diet?
Do you use tobacco?
Do you use controlled substances?

Women: Are you Pregnant/Trying to get pregnant? Taking oral contraceptives? Nursing?

Are you allergic to any of the following?
Aspirin, Penicillin, Codeine, Local Anesthetics, Acrylic, Metal, Latex, Sulfa drugs, Other

- Do you have, or have you had, any of the following?
AIDS/HIV Positive, Alzheimer's Disease, Anaphylaxis, Anemia, Angina, Arthritis/Gout, Artificial Heart Valve, Artificial Joint, Asthma, Blood Disease, Blood Transfusion, Breathing Problem, Bruise Easily, Cancer, Chemotherapy, Chest Pains, Cold Sores/Fever Blisters, Congenital Heart Disorder, Convulsions, Cortisone Medicine, Diabetes, Drug Addiction, Easily Winded, Emphysema, Epilepsy or Seizures, Excessive Bleeding, Excessive Thirst, Fainting Spells/Dizziness, Frequent Cough, Frequent Diarrhea, Frequent Headaches, Genital Herpes, Glaucoma, Hay Fever, Heart Attack/Failure, Heart Murmur, Heart Pacemaker, Heart Trouble/Disease, Hemophilia, Hepatitis A, Hepatitis B or C, Herpes, High Blood Pressure, High Cholesterol, Hives or Rash, Hypoglycemia, Irregular Heartbeat, Kidney Problems, Leukemia, Liver Disease, Low Blood Pressure, Lung Disease, Mitral Valve Prolapse, Osteoporosis, Pain in Jaw Joints, Parathyroid Disease, Psychiatric Care, Radiation Treatments, Recent Weight Loss, Renal Dialysis, Rheumatic Fever, Rheumatism, Scarlet Fever, Shingles, Sickle Cell Disease, Sinus Trouble, Spina Bifida, Stomach/Intestinal Disease, Stroke, Swelling of Limbs, Thyroid Disease, Tonsillitis, Tuberculosis, Tumors or Growths, Ulcers, Venereal Disease, Yellow Jaundice

Have you ever had any serious illness not listed above?

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 _____



Philip W.S. Park DDS.

**ACKNOWLEDGEMENT OF RECEIPT OF
HIPAA NOTICE OF PRIVACY PRACTICES
("Acknowledgement")**

I acknowledge that I have received a copy of this Dental Practice's HIPAA Notice of Privacy Practices.

Patient Name (Please Print)

Patient Signature

Date

OR

Signature of Personal Representative

Authority of Personal Representative to Sign for Patient (check one):

- Parent Guardian Power of Attorney Other: _____

Please Note: It is your right to refuse to sign this Acknowledgement.

Dental Office Use Only

I tried to obtain written Acknowledgement by the individual noted above of receipt of our **Notice of Privacy Practices**, but it could not be obtained because:

- ___ An emergency prevented us from obtaining acknowledgement.
- ___ A communication barrier prevented us from obtaining acknowledgement.
- ___ The individual was unwilling to sign.
- ___ Other: _____

Staff Member Signature

Date



**531W. 7th St. - San Pedro, CA 90731
310-831-0003**

Insured:
Patient:
Insurance:
ID #
Group #

Legal Assignment of Benefits and Designation of Authorized Representative Authorized Representative

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to the above named healthcare provider(s), as my designated Authorized Representative(s), all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such provider(s), regardless of such provider's managed care network participation status., I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorizes the above named provider(s) to release all medical information necessary to process my claims under HIPAA. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release such provider(s) any and all plan documents, insurance policy and/or settlement information upon written request from such provider(s) in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named provider(s), to the full extent permissible under the law and under any applicable employee group health plan(s), insurance policies or liability claim, any claim, chose in action, or other right I may have to such group health plans, health insurance issuers or tortfeasor insurer(s) under any applicable insurance policies, employee benefit plan(s) or public policies with respect to medical expenses incurred as a result of the medical services I received from the above named provider(s), and to the full extent permissible under the law to claim or lien such medical benefits, settlement, insurance reimbursement and any applicable remedies, including, but are not limited to, (1) obtaining information about the claim to the same extent as the assignor; (2) submitting evidence; (3) making statements about facts or law; (4) making any request, or giving, or receiving any notice about appeal proceedings; and (5) any administrative and judicial actions by such provider(s) to pursue such claim, chose in action or right against any liable party or employee group health plan(s), including, if necessary, bring suit by such provider(s) against any such liable party or employee group health plan in my name with derivative standing but at such provider(s) expenses. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal or state laws. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Signature of Insured / Guardian

Date

Signature of Claimant, if other than Insured

Date



Insurance Policies and Guidelines

The purpose of this is to let you know how our office works in handling of your insurance claims. We do this to eliminate any questions or misunderstandings that could arise and later affect your ability to use your policies as they were intended.

We ITEMIZE all our procedures. The reason for this is to let the company personnel know exactly what was done on each visit, what was not done, and why. In reporting to insurance companies, we are responsible to them on your behalf to accurately inform them as to your condition, status, any complications, exacerbations, unusual circumstances, etc., letting them know how long we anticipate you to need our care and what frequency. All this involves a tremendous amount of staff and professional time and expense. We do this as a service to you. All we ask for is your cooperation.

Because we itemize every procedure rather than just describe what is being done as an "office visit", the charges per visit can vary. We know there are a lot of charges that will not be paid for various reasons, such as maximum dollar amount limits per visit, procedures that the policy doesn't cover, etc., and we expect to receive denials on claims as it's the nature of the insurance industry. However, we are still going to bill for everything we do whether we get paid or not, so that we can adequately communicate with these companies.

Our experience shows that a company that receives billings that describe your visit to an office as an "adjustment" do not understand what is being done and why. Some have taken the position that billings sent in this way imply that you are haphazardly receiving adjustments without any diagnostic criteria to objectively determine if any adjustment is needed on that visit. They look at this practice in reporting the same way they would if an M.D. were just randomly give out shots or pills to every patient without first determining whether or not that patient actually needed anything done that visit. It just isn't good practice.

Some companies pay 100%, some pay 90%, some pay 80%, some pay 50%, some pay for x-rays but not exams, some pay for exams but not x-rays, some only pay for an adjustment, some pay for everything but the adjustment. Medicare pays for approximately 12-24 visits a year demanding that x-rays be taken but not paying for them or the exams that the patient must have, and the list goes on and on. We only state this so that you are aware of the practices that exist within the insurance industry.

We also want you to know that what you are responsible for is your deductible and the co-pay that your policy says you must pay. If you have an 80%/20% policy, then the amount you are responsible for is the 20%. If you have a special financial situation that makes this difficult or impossible for you, you have only to speak to one of the staff and arrangements will be made so that you can receive the care you need at a fee you can afford. We cannot, however, read minds; you must tell us, then we can help you.

Any correspondence that you receive must be brought to us so that we may have a copy of it for your records (often the patient receives information that is vital to processing a claim that never finds its way to the doctor's office). We ask that you please help us help you by doing this. Please understand that our purpose is to help all people, not just those who can afford it. By following the above policies, this is made possible.

Please sign your name below indicating that you have read the above and understand it. Thank you.

Patient's Signature

Date

OFFICE POLICY

PAYMENT IS DUE WHEN SERVICE IS RENDERED. We will bill most insurance companies for you as a courtesy, provided we have all the necessary information. It is your responsibility to verify with your insurance carrier as to whether you are covered for the medical services provided to you, e.g. physician consults, injections, diagnostic testing, lab testing. Any deductibles, co-payments, or balances not paid by the insurance company are your financial responsibility. This applies to all insurances including Medicare.

CO-PAYMENTS AND DEDUCTIBLES ARE DUE WHEN SERVICES ARE RENDERED. Insured patients are responsible for all charges not paid by the insurance company within 45 days after the date of service. Payment arrangements can be made on an individual basis **AT OUR DISCRETION**. We reserve the right to withdraw the extension of credit.

CANCELLATION POLICY. Patients who fail to cancel an appointment within 24 hours of the appointment time may be subject to a fee up to your co-payment amount billed directly to the patient.

RETURNED CHECKS POLICY. PLEASE BE ADVISED THERE IS A SERVICE FEE OF \$20.00 ON ALL RETURNED CHECKS.

PATIENT AGREEMENT AND ASSIGNMENT OF INSURANCE BENEFITS.

I agree to pay reasonable attorney's fees and costs should legal proceedings be necessary to collect any portion of the bill or to enforce this agreement. I also agree to permit my Physician to consult with any other Physician should he/she believe it necessary and I agree to pay for said consult. If any surgical procedures are to be performed, I authorize my Physician to engage the services of another Physician and I agree to pay for said services. I hereby authorize my Physician to release any information acquired in the course of my examination and treatment. I further authorize payment of insurance benefits to be paid directly to my Physician.

AGREEMENT TO DISCLOSE INFORMATION. I hereby state that my ailment, injury (ies), etc., are not due to any type of personal injury, motor vehicle accident, etc., for which I am seeking damages. I agree that if at any time after receiving treatment as a direct result of any type of motor vehicle accident or personal injury, I will disclose this information to *A+ DENTAL* and sign the appropriate lien(s) in favor of *A+ DENTAL*, Philip W.S. Park D.D.S., and staff. I understand that the disclosure of insurance and other information is necessary in order that the services I receive are paid in full. The non-disclosure of the information to Torrance Family and Urgent Care pertaining to my legal case for said injury might make me personally responsible for all charges incurred at the Torrance Family and Urgent Care.

PATIENT UNDERSTANDING OF OWNERSHIP. I understand that *A+ DENTAL* is owned by Philip W.S. Park DDS.

CONSENT TO TREATMENT. I understand that the treatment to be received by me at the *A+ DENTAL* will be administered only upon full and complete disclosure of benefits, potential risks, and complications of said treatments, and that my informed consent to the treatment to be received by me will be obtained prior to my receiving said treatment.

I declare under penalty of perjury under the laws of the State of California that I have read the foregoing, that I understand it, and that by executing this document on this ____ day of _____, 20__, in the City of San Pedro, I accept and agree to its contents.

Patient's Signature _____ Date of Birth _____

Print Name _____ Date _____

(Please print clearly)

Parent/Guardian _____ Date _____