TIME 03:33 PM

DATE 1/31/2017

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

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

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: Rem. Deduct:

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: Rem. Deduct:

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

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

Are you under a physician's care now?	Yes	No	If yes
Have you ever been hospitalized or had a major operation?	Yes	No	If yes
Have you ever had a serious head or neck injury?	Yes	No	If yes
Are you taking any medications, pills, or drugs?	Yes	No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	Yes	No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes	No	If yes
Are you on a special diet?	Yes	No	
Do you use tobacco?	Yes	No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

Do you use controlled substances? Yes No If yes

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

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

Have you ever had any serious illness not listed Yes No If yes

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:

X Date:_____

Berryville Dental Associates

Gina Kaiser, D.D.S. Nicole Malony, D.D.S.

BROKEN APPOINTMENT POLICY

A broken appointment is considered: a cancelled appointment without 24 hour notice or an appointment where the patient does not show as scheduled.

We ask for at least 24 hours advance notice for canceling or rescheduling an appointment; otherwise a $50 broken appointment fee may be assessed to your account. We understand that there may be some extenuating circumstance for which you have no control. We will take that into consideration. We will allow two unexcused broken appointments per patient before patient dismissal from the practice.

Note: All Cancellation/Broken Appointment fees must be paid prior to scheduling another appointment.

A broken appointment is a loss to three people:

- The patient who missed the valuable time
- Another patient who could have taken the valuable time
- The dentist who was fully staffed and prepared for the appointment

The treatment that is planned for you is specific to you. It is important for you to keep the scheduled date and time to properly complete your treatment.

Here at Kaiser and Malony, DDS, PC we strive to give quality care to our patients. By keeping your scheduled appointment you enable us to better serve you.

Please sign below signifying your understanding of this policy.

Print patient name: _____ Signature: _____

Parent or Guardian Signature: _____ Date: _____

Kaiser and Malony D.D.S., PC 322 North Buckmarsh Street Suite B Berryville, VA 22611 Office 540.955.0270 Fax 540.955.0272

Berryville Dental Associates

Gina Kaiser, D.D.S. Nicole Malony, D.D.S.

Financial Responsibility Agreement and Consent to Services

Thank you for choosing our team of dental professionals to serve your dental needs. We are committed to providing you with the highest quality care. We appreciate the confidence you have placed in us and will do everything possible to continue to warrant your confidence as we serve you. In order to continue providing outstanding care to all of our patients, we ask that you please understand and agree to the following office financial policy.

Insurance:

Dental insurance is designed to help offset the cost of dental care. Insurance estimates provide a table of allowances that will assist you in determining your approximate out-of-pocket expenses.

1. Filing insurance claims is a courtesy that we will gladly perform for you to help you maximize your benefits. However, you are responsible for any amount not covered by your insurance, *whatever the reason*.
2. On your behalf, we will contact your insurance company to help determine your level of benefits. Please note that insurance estimates and pre-estimates are not a guarantee from your insurance company.
3. Your insurance policy is a contract between your employer and your employer's insurance company, we are not party to that agreement. Our office cannot accept responsibility for negotiating a settlement with your insurance company on a disputed claim.
4. We generally will accept assignment of benefits (payment) from your insurance company but we reserve the right to refuse assignment on certain plans. In that case, full payment is due by you at the time of service and your insurance company will reimburse you directly.
5. In the event that you wish to have us invoice your insurance company directly, you are agreeing to the following statement: I request the payment of authorized insurance benefits for any services furnished to me be made on my behalf to Kaiser and Malony, DDS, PC.

Payment Policies:

As a condition of your treatment by this office, financial arrangements must be made in advance. We depend upon payment from our parties for the costs incurred in their care and the financial responsibility on the part of each patient must be determined before treatment. Account payment options available include: Cash, Check, Visa, Master Card, or Care Credit.

By signing below you are agreeing to all of the terms contained in this Financial Responsibility Agreement and Consent for Services including the following:

1. If you have dental insurance, your estimated portion of payment is *due in full at your time of service*.
2. If you do not have dental insurance, payment for services is *due in full at your time of service*.
3. There is a $35.00 service charge on all returned checks.
4. We reserve the right to charge a missed appointment fee for no-shows or cancellations with less than 24 hours notice.
5. I understand and agree that any account balance not paid within 90 days will be subject to collection activity. I understand Kaiser and Malony, DDS, PC will retain the services of an attorney or collection agency to assist with the collection of any outstanding balance.
6. I understand and agree that I owe an attorney's and/or collection agency's fee of an additional 40% of the amount I owe to Kaiser and Malony, DDS, PC plus 1 ½% per month (18% per annum) on the unpaid balance owed, plus court costs on any account not paid within 90 days of last date of service.
7. I understand and agree that, ultimately, I am responsible for payment on my account. As guarantor, I am responsible for any outstanding balances for other family members listed on the same account, due to Kaiser and Malony, DDS, PC. I understand that all subsequent appointments for the guarantor and/or family members on the same account will not be scheduled until all outstanding balances are paid in full. I understand that any account submitted for collections will be dismissed from the practice.

Print Patient Name: _____ **Signature:** _____

Parent or Guardian Signature: _____ **Date:** _____