TIME 07:18 AM

DATE 9/30/2024

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:

Gender: ☐ Male ☐ Female ☐ Unknown 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:

EMERGENCY CONTACT:

EMERGENCY PHONE:

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:

Eagle Lake Family Dentistry
Medical History

Patient Name: _____ **Date of Birth:** _____ **Today's 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.

Have you been told you need to premedicate with an antibiotic prior to any dental visits?	☐ Yes ☐ No	If yes _____
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 _____
Are you on any blood thinners (Coumadin, Warfarin, Daily Aspirin)? Dosage?	☐ Yes ☐ No	If yes _____
Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates?	☐ Yes ☐ No	If yes _____
Do you take or have you taken Phen-Fen or Redux?	☐ Yes ☐ No	If yes _____
Are you taking any other meds, pills, or drugs?	☐ Yes ☐ No	If yes _____
Have you ever had a serious head or neck injury?	☐ Yes ☐ No	If yes _____
Have you had a history or head or neck radiation treatments?	☐ Yes ☐ No	If yes _____
Are you on a special diet?	☐ Yes ☐ No	If yes _____
Do you use tobacco?	☐ Yes ☐ No	If yes _____

Women:

☐ Are you pregnant? ☐ Nursing? ☐ Taking oral contraceptives?
☐ Are you trying to get pregnant?

Are you allergic to any of the following?

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

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 Disease ☐ Yes ☐ No
Breathing Problems ☐ Yes ☐ No	Frequent Headaches ☐ Yes ☐ No	Liver Disease ☐ Yes ☐ No	Stroke ☐ Yes ☐ No
Bruises 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	Tonsilitis ☐ 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
Congenial 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 a serious illness not listed above? ☐ Yes ☐ No If Yes _____

Comments: _____

Signature of Patient, Parent or Guardian: _____

Eagle Lake Family Dentistry
104 Plainview St.
Eagle Lake, MN 56024
(507) 257-3800 or 1 (888) 764-5362

Patient Treatment and Financial Policy

The following is a statement of our Financial Policy, which we require that you read, agree to, and sign prior to any treatment.

Financial and Patient Policies:

- Cash, Personal Check, or Credit Card payments are accepted, and a 5% courtesy discount will apply for balances paid the day of service. initial_____
- A service charge of 22% annually begins accruing on any unpaid balance after 30 days. initial_____
- In the event a personal check is returned to our office due to insufficient funds, an additional $35 fee will be added to your account. initial_____
- Minors accompanied by the parent or legal guardian who has consented to treatment are responsible for full payment at time of service. This includes divorced parents regardless of what a divorce decree may state. initial_____
- **Unaccompanied Minors:** The parent or legal guardian is responsible for full payment at time of service. Treatment consents and payment arrangements with the parent or legal guardian *must* be made prior to appointment or non-emergency treatment may be denied. initial_____
- **Missed Appointment (s) and Cancellations:** We require at least a 24-hour notice for cancellations or for re-scheduling your appointment. A charge may be assessed for multiple missed, short notice or cancelled appointments. Multiple failed appointments may result in being dismissed from the dental practice. initial_____

I have read all information and agree to all terms:
Sign: _____Date: _____

Patients with Dental Insurance:

- As a courtesy to you, we will help you process all your dental insurance claims. However, you are responsible to contact your insurance regarding coverage. initial_____
- Please understand that we will provide an insurance estimate to you: however, it is **NOT** a guarantee that your insurance will pay exactly as estimated. initial_____
- We **MUST** emphasize that as your dental care provider, our relationship is with *you*, our patient, **NOT** with your insurance company. Your insurance policy is a contract between you and your insurance company, and our office is not a party to that contract. initial_____
- All charges you incur are your responsibility, regardless of your insurance coverage. You are responsible to know limitations such as waiting periods, frequencies, age restrictions, deductibles, and maximums. initial_____
- Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. initial_____
- This form instructs your insurance company to make payment directly to our office I authorize the release of any information concerning my (or my child's) health care advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. initial_____

Please sign below: _____

Eagle Lake Family Dentistry
104 Plainview St.
Eagle Lake, MN 56024
(507) 257-3800

Notice of Privacy Practices
Patient Acknowledgement

Patient Name: _____
Date of Birth: ____/____/_____

I have received and understand this practice's Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at or controlled by this practice. If changes to the policy occur, this practice will provide me a revised Notice of Privacy Practices upon request.

By my signature below, I indicate my consent to receive automated and/or prerecorded phone calls and text messages from Eagle Lake Dentistry or its business associates, regarding my account or health care (including but not limited to appointment and refill or medication reminders) on my residential phone line and/or cellular phone. I understand that if I do not wish to receive such automated and/or prerecorded phone calls and text messages, I may indicate such preferences here: _____

Signature: _____
Date: ___/___/____

Relationship to patient (if signed by a person representative of patient):_____

Eagle Lake Family Dentistry

PO Box 97 Eagle Lake, MN 56024 507-257-3800

Date_____

Dental Office

_____

_____

_____

_____

I authorize your office to send a copy of the most recent radiographs to racheleaglelakedentistry@gmail.com . Thank you in advance for you timely response to this letter.

Patient
Name(s)_____DOB_____

_____

_____

_____

Patient/Guardian
Signature_____Date_____