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:

CHILD DENTAL MEDICAL HISTORY

PATIENT NAME: Last _____ First _____ MI _____ Date of Birth _____

PATIENT'S GUARDIAN'S NAME: _____

COMMENTS

DENTAL HISTORY – CIRCLE THE APPROPRIATE ANSWER

1. Is this your child's first visit to a dentist? ..... YES NO
2. If not, how long since your child's last visit to the dentist? _____
3. Were any x-rays or radiographs taken at a previous dental visit? ..... YES NO
4. Does your child eat between meals? ..... YES NO
5. Does your child eat sweets, such as candy, soda pop, chewing gum? ..... YES NO
6. When does your child brush his/her teeth?
   ___Upon Asking ___After eating any food ___Right after meals ___Before bed
7. How does your child receive Fluoride?
   ___Community water level___ppm ___Well water level___ppm
   ___Fluoride drops or tablets ___Fluoride rinse or gel
8. Have any cavities been noted in the past? ..... YES NO
9. Does your child suck his/her thumb or fingers? ..... YES NO
10. Were any teeth (baby or permanent) removed by extraction? ..... YES NO
    Was it suggested that the space be maintained? ..... YES NO
    Was an appliance placed? ..... YES NO
11. Have there been any injuries to teeth, such as falls, blows, chips, etc? ..... YES NO
    If so, describe _____
12. Has your child had any problem with dental treatment in the past? ..... YES NO
13. Has anyone in the family, including parents, had orthodontics? ..... YES NO
14. Has your child ever received a local anesthetic? ..... YES NO
15. Has your child ever had occlusal sealants? ..... YES NO
16. Does your child think there is anything wrong with his/her teeth? ..... YES NO

MEDICAL HISTORY

1. Does your child have any health problems? ..... YES NO
2. Is your child under the care of a physician? ..... YES NO
   If yes, since when and why? _____
3. Name of physician? _____
4. Is your child receiving any medication? ..... YES NO
   What? _____
5. Is your child allergic to penicillin, antibiotics or other drugs? ..... YES NO
6. Is your child allergic to or sensitive to any metals or latex? ..... YES NO
7. Does your child have any other allergies? ..... YES NO
8. Has your child had any serious illness? ..... YES NO
   When _____ What _____
9. Has your child ever had surgery? ..... YES NO
10. Does your child have a heart murmur? ..... YES NO
11. Is surgery contemplated? ..... YES NO
12. Does your child experience severe or prolonged bleeding? ..... YES NO
13. Does your child have AIDS or has he/she tested HIV positive? ..... YES NO
14. Has your child tested positive for hepatitis? ..... YES NO
15. Is your child subject to nervous disorders? ..... YES NO
    ___Fainting? ___Seizures? ___Dizziness? ___Behavioral/Learning Problems?
16. Does your child have frequent headaches? ..... YES NO
17. Has your child had a history of: (Circle all that apply) diabetes, heart trouble, asthma, kidney infection, rheumatic fever, epilepsy, cerebral palsy, liver problems, cancer, infection, congenital birth defects, mental retardation, eyesight problems, speech impairments, hearing loss.

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT/ GUARDIAN SIGNATURE _____ DATE _____

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_____