Account #:_____ Patient Name:_____

CAMPUS
FAMILY DENTAL

PATIENT REGISTRATION

First Name: _____ Last Name: _____ Middle Initial: ____

Preferred Name: _____ Patient is: ( ) Policy Holder
( ) Responsible Party

Responsible Party (parent/guardian if minor)

First Name: _____ Last Name: _____ Middle Initial: ____

Address: _____ Address 2:_____

City, State, Zip: _____Home Phone: _____ _____

Name of Employer: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc. Sec. _____ Driver Lic: _____

( ) Responsible Party is also a Policy Holder for Patient

Patient Information

Address: _____ Address: _____

City: _____ State/Zip: _____ Home Phone: _____

Name of Employer:_____ 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.

Employment Status: ( ) Full Time ( ) Part Time ( ) Retired Additional Comments:
Student Status: ( ) Full Time ( ) Part Time

Employer ID: _____ Pref. Dentist: _____

Carrier ID: _____ Pref. Pharmacy: _____

In order to maximize your insurance benefits to the fullest, please complete the following if card not provided:

Account #:_____ Patient Name:_____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ( ) Self ( ) Spouse ( ) Child ( ) Other

Insured Soc. Sec. _____ Insured Birth Date: _____

Employer: _____ Insurance Company: _____ Group #: _____

Address: _____ Address: _____

City, State, Zip: _____ City, State, Zip: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ( ) Self ( ) Spouse ( ) Child ( ) Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Insurance Company: _____ Group #: _____

Address: _____ Address: _____

City, State, Zip: _____ City, State, Zip: _____

Emergency Contact

Name: _____ Home/Cell Phone: _____

Relationship: _____ Work Phone: _____

How did you hear about our office?

( ) www.purezendentistry.com ( ) Google ( ) Yelp ( ) Facebook ( ) ZocDoc ( ) Amazon Local ( ) Living Social

( ) Doctor's Office:_____ ( ) Provider:_____ ( ) Friend/Relative:_____

( ) Other Source:_____ ( ) Not Referred

DENTAL HISTORY

Date of Last Dental Visit: _____

Do you have any concerns you would like the staff to know about? ( ) Yes ( ) No If yes, please explain: _____

Do your gums bleed when you brush or floss ( ) Yes ( ) No If yes, please explain: _____

Are you sensitive to cold, hot, sweets or pressure? If yes which one(s) ( ) Yes ( ) No If yes, please explain: _____

Have you ever had problems associated with previous dental treatment? ( ) Yes ( ) No If yes, please explain:_____

Account #:_____ Patient Name:_____

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is 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? ( ) Yes ( ) No If yes, please explain: _____
Have you ever had a serious head or neck injury? ( ) Yes ( ) No If yes, please explain: _____
Do you take blood thinners? ( ) Yes ( ) No If yes, please explain: _____
Are you taking any medications? ( ) Yes ( ) No If yes, please explain:_____
Do you use any controlled substance? ( ) Yes ( ) No _____
Do you use tobacco? ( ) Yes ( ) No _____
Do you require Pre-Medicate? ( ) Yes ( ) No _____
If yes what medication? _____ Who is your physician? _____

Women:
( ) Pregnant/Trying to get pregnant? ( ) Nursing? ( ) Taking oral contraceptives?

Are you allergic to any of the following?

( ) Acrylic ( ) Aspirin (NSAIDS) ( ) Codeine ( ) Acrylic ( ) Latex
( ) Local Anesthetics ( )Metals ( ) Penicillin ( ) Acrylic ( ) Sulfa Drugs

( ) Other: Please explain: _____
Are you taking any of blood thinner medications?
If yes, please explain: _____

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

( ) AIDS/HIV Positive	( ) Alzheimer's Disease	( ) Anaphylaxis	( ) Anemia
( ) Angina/chest pains	( ) Arthritis/Gout	( ) Artificial Heart Valve	( ) Artificial Joint
( ) Asthma	( ) Blood Disease	( ) Blood Transfusion	( ) Breathing/Lung Problems
( ) Bruise Easily	( ) Cancer	( ) Chemotherapy	( ) Congenital Heart Disease
( ) Cortisone Treatment	( ) Depression/Anxiety	( ) Diabetes	( ) Drug Addiction
( ) Epilepsy/Seizures	( ) Excessive Bleeding	( ) Excessive Thirst	( ) Fainting Spells/dizziness
( ) Frequent cough	( ) Frequent Diarrhea	( ) Frequent Headaches	( ) Glaucoma
( ) Heart Attack/Failure	( ) Heart Disease	( ) Heart Murmur	( ) Heart Pacemaker
( ) Asthma	( ) Fainting Spell/Dizziness	( ) Hepatitis B or C	( ) High Blood Pressure
( ) Blood Disease	( ) Frequent Cough	( ) Kidney Problems	( ) Leukemia
( ) Blood Transfusion	( ) Frequent Diarrhea	( ) Mitral Valve Prolapse	( ) Osteoporosis
( ) Bone Density problems	( ) Frequent Headaches	( ) Renal Dialysis	( ) Rheumatic Fever
( ) Breathing Problems	( ) Genital Herpes	( ) Stomach/intestinal problems	( ) Stroke
( ) Bruise Easily	( ) Glaucoma	( ) Ulcers	( ) Venereal disease
( ) Cancer	( ) Hay Fever	( ) Osteopenia	( ) Tumors or Growths
( ) Chemotherapy	( ) Heart Attack/Failure	( ) Pain in Jaw Joint	( ) Ulcers
( ) Chest Pains	( ) Heart Murmur	( ) Parathyroid Disease	
( ) Cold Sores/Fever Blisters	( ) Heart Pace Maker	( ) Psychiatric Care	( ) Yellow Jaundice
( ) Congenital Heart Disorder	( ) Heart Trouble/Disease	( ) Radiation Treatments	
( ) Convulsions	( ) Hemophilia	( ) Recent Weight Loss	

Have you ever had any serious illness not listed above? ( ) Yes ( ) No
If yes, please explain:_____

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 (Legal Guardian, if Minor) Date

_____ _____
Doctor's Signature Date

Account #:_____ Patient Name:_____

NOTICE OF PRIVACY ACTS

THIS TREATMENT DESCRIBES HOW MEDICAL INFROMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This practice is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment
We may disclose your health care information to other health care professionals within our practice for the purpose of treatment, payment or health care operations.

Payment
We may disclose your health care information to your insurance provider for the purpose of payment or health care operations.

Worker's Compensation
We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies
We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care, about your medical condition or in the event of an emergency or of your death.

Public Health
As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings
We may disclose your health information in the course of any administrative or judicial proceedings.

Law Enforcement
We may disclose your health information to a law enforcement official for the purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons
We may disclose your health information to coroners or medical examiners.

Organ Donation
We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research
We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety
It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies
We may disclose your health information for military, national security, prisoner and government benefits and purposes.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that this practice is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method of communication or delivery, upon your request.
- You have the right to inspect and request a copy of your health information.
- You have a right to request that this practice amend your protected health information. Please be advised, however, that this practice is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by this practice.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices
This practice reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, this practice is required by law to comply with this Notice.

This practice is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice, or if you want more information about your privacy rights, please contact our Privacy Officer by calling this office.

Complaints
Complaints about your privacy rights, or how this practice has handled your health information should be directed to our Privacy Officer by calling this office.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights 200
Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of _____/_____/_____.

Account #:_____ Patient Name:_____

ACNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this Acknowledgement

I have had full opportunity to read, understand the contents, and I have received a copy of this office's Notice of Privacy Practices. I understand that by signing this form, I am giving my consent for use and disclosure of my protected health information to carry out all payment activities and health care operations.

Patient's name _____ Date _____

Signature _____
(Parent/Guardian if minor)

AUTHORIZATION FOR COMMUNICATION

I authorize Campus Family Dental to release the following information about my health care (please check all that apply):

□ Any and all information

□ Information necessary to schedule, confirm, cancel, or reschedule appointments

□ Information about prescriptions

□ Information about my bills or account

□ I grant permission to this individual to bring my child to his/her appointments

This authorization applies to the following individual(s)

Name: Relationship to the Patient:

_____ _____

_____ _____

□ I choose not to authorize any individuals at this time

I understand that this authorization is valid until revoked by the patient, or the patient's parent/guardian.

Account #:_____ Patient Name:_____

CAMPUS
FAMILY DENTAL

Consent for Dental Treatment

I, _____, hereby consent to the procedures as described to be completed under the direction of:
(Patient's printed name)

Dr. Eric Hein and/or Associates

During this visit, I may be notified of the need to undergo additional dental treatment.

I will be fully informed about the details of the recommended treatment and alternatives, if any. I agree to accept the treatment as recommended by the doctor.

I understand that as the treatment proceeds there may be need to change the treatment plan. If this occurs I will be informed before any change is instituted.

I further understand that individual reactions to treatment cannot be predicted. If I experience any unanticipated reactions during or following any treatment, I will report them to the office as soon as possible. It is very important to provide the dentist with accurate information before, during and after treatment. I will be told that the success of the recommended treatment depends upon my cooperation in keeping scheduled appointments, following home care instructions including oral hygiene and dietary instructions and reporting to the office any change in my health status as soon as possible. Remember, the patient plays a key role in the success of the treatment plan.

I will discuss all of the above with the doctor, as well as any questions I may have.

I acknowledge that no guarantees or assurances will be given by anyone as to the results that may be obtained.

If you are a woman on oral birth control you must consider the fact that antibiotics might make oral birth control less effective. Please consult with your physician as an alternative form of birth control during the course of the antibiotic.

Following the explanation of recommended treatment and subsequent discussion, including sufficient answers to my questions, I authorize the doctor to complete the treatment as described.

_____ _____

Patient's Signature (Parent/Guardian, if minor) Date

Account #:_____ Patient Name:_____

CAMPUS
FAMILY DENTAL

FINANCIAL POLICY

We feel that all patients deserve from us the very best dental care we can provide.
Further, we feel that everyone benefits when definite financial arrangements are agreed upon.

INSURANCE

While the filing of commercial insurance is a courtesy that we extend to our patients, all charges for services and materials are your responsibility from the date services are rendered, unless our office has a contractual agreement with your dental plan prohibiting a portion of the charges. In this instance you will be responsible for all charges up to the contracted fee. A 45-day grace period will be allowed for insurance payment, provided co-payments are made at time of service. Prepayment of services may be required for extensive treatments plans.

Commercial insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. Our fees reflect our services, not an insurance company's reimbursement schedule. Certain insurance companies may choose not to pay your dental fee in full. This is not uncommon and is unfortunate for those affected by this problem. If your insurance company selects a level of reimbursement (an arbitrary value sometimes referred to as "usual and customary") which is below our standard fees, the responsibility of the remaining balance is placed on you when applicable. The payment schedule will be based upon the estimated benefit coverage provided by your insurance company.

Should your insurance company choose not to accept Assignment of Benefits (An arrangement by which a patient requests that their health benefit payments be made directly to the provider) payment in full will be due at time of service. As a courtesy to you, however, our office will still file the insurance claim on your behalf for direct reimbursement.

PREDETERMINATION OF INSURANCE BENEFIT

A predetermination of benefits is a written request for verification of benefits. Although insurance will not guarantee payment until a claim is received and processed, a predetermination gives an estimate of how much of a proposed treatment plan will be covered under your dental program. A predetermination lets you figure your costs before you receive major treatment. We will be happy to file a predetermination of insurance benefit on your behalf for major or unusual services. There is an administrative charge of $25.00 to file the predetermination. This fee will be applied toward balance once treatment has been initiated.

MINOR PATIENTS

The adult accompanying a minor and the parents (or guardians of the minor) is responsible for payment. For unaccompanied minors, non-emergency treatment will be denied unless prepayment has been made for serviced to be rendered.

NSF CHECKS

All checks returned for non-sufficient funds will incur a $27.50 service fee.

DELINQUENT ACCOUNTS

Should the account become delinquent (past 45 days), the patient (parent/guardian if patient is a minor), will be responsible for all collection costs including agency fees, attorney fees, court fees, or any other fees incurred to collect this debt.

AUTHORIZATION AND RELEASE

I authorize the Dentist to release any information including the diagnosis and the records of any treatment or examination rendered during the period of such dental care to third party payers and/or other health care practitioners. I authorize and request my insurance company to pay directly to the Dentist or Practice, insurance benefits otherwise payable to me.

I have read and agree to the above financial policy.

x_____ _____
Signature of patient (Parent/Guardian if minor) Date