Eric R. Claussen, DMD, PA
Oral and Maxillofacial Surgery

Patient Registration Form

American Dental Association
www.ada.org

Email:			Today's Date:
Preferred Name: o Miss o Mr. o Mrs. o Ms. o Dr.		Referred by:	
Name: Last First Middle		Home Phone: *include area code* ( )	Cell Phone: *include area code* ( )
Address: Mailing address		City:	State: Zip:
SS#:		Date of Birth:	Sex: M F
Employer:		Business Phone: *include area code* ( )	
Emergency Contact:	Relationship:	Home Phone: *include area code* ( )	Cell Phone: *include area code* ( )
College Student Status: o Full Time o Part Time	Please provide school info:	School Name:	
Employment Status: o Full Time o Part Time o Retired		Address:	
Marital Status: o Married o Single o Divorced o Separated o Widowed		Address 2:	
Pref. Pharmacy:	Phone: ( )	City, State, Zip:	

Reason for Visit

Name of Referring Dentist:
Did you bring Pano / X-Rays: yes / no
Describe symptoms / reason for visit:

Dental Insurance Information

Primary Insurance Information

Name of Insured: _____ Relationship to Patient: o Self o Spouse o Child o Other

Insured Soc. Sec.: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

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

ID#: _____ Gr#: _____

Secondary Insurance Information

Name of Insured: _____

Insured Soc. Sec.: _____ Relationship to Patient: o Self o Spouse o Child o Other

Employer: _____ Insured Birth Date: _____

Address: _____ Ins. Company: _____

Address 2: _____ Address: _____

City, State, Zip: _____ Address 2: _____

ID#: _____ Gr#: _____ City, State, Zip: _____

Medical Primary Insurance Information

Primary Insurance Information

Name of Insured: _____ Relationship to Patient: o Self o Spouse o Child o Other

Insured Soc. Sec.: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

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

ID#: _____ Gr#: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Patient: o Self o Spouse o Child o Other

Insured Soc. Sec.: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

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

ID#: _____ Gr#: _____

Medical Information Please mark (X) your responses to indicate if you have or have not had any of the following diseases or problems.

(Check DK if you Don't Know the answer to the question)	Yes	No	DK
Are you now under the care of a physician?	o	o	o
Physician Name: _____			
Phone: *include area code* (_____) _____			
Address/City/State/Zip: _____			
Are you in good health?	o	o	o
Has there been any change in your general health within the past year?	o	o	o
If yes, what condition was treated? _____			
Date of last physical exam: _____			
Do you wear contact lenses?	o	o	o
Are you taking, or have you taken, any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine) or fen-phen (fenfluramine-phentermine combination)?	o	o	o
Are you taking or scheduled to begin taking either of the medications alendrontate (Fosamax®) or risendronate (Actonel®) for osteoporosis or Paget's disease?	o	o	o
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastic cancer?	o	o	o
Date Treatment Began: _____			

	Yes	No	DK
Have you had a serious illness, operation or been hospitalized in the past 5 years?	o	o	o
If yes, what was the illness or problem? _____			
Are you taking or have you recently taken any prescription(s) or over the counter medicine(s)?	o	o	o
If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements: _____			
Do you use controlled substances (drugs)?	o	o	o
Do you use tobacco (smoking, snuff, chew, bidis)?	o	o	o
If so, how interested are you in stopping? Circle one: VERY / SOMEWHAT / NOT INTERESTED			
Do you drink alcoholic beverages?	o	o	o
If yes, how much alcohol did you drink in the last 24 hours? _____			
If yes, how much do you typically drink in a week? _____			
WOMEN ONLY Are You: Pregnant?	o	o	o
Number of weeks: _____			
Taking birth control pills or hormone replacement?	o	o	o
Nursing?	o	o	o

Joint Replacement. Have you had an orthopedic total joint replacement (hip, knee, elbow, finger)? . . . . . o o o
Date:_____ If yes, have you had any complications?

Allergies - Are you allergic to, or have you had a reaction to: **Yes No DK**
To all **yes** responses, specify type of reaction.

Local anesthetics_____ o o o
Aspirin_____ o o o
Penicillin or other antibiotics_____ o o o
Barbituates, sedatives, or sleeping pills_____ o o o
Sulfa drugs_____ o o o
Codeine or other narcotics_____ o o o
Metals_____ o o o
Latex (rubber)_____ o o o
Iodine_____ o o o
Hay fever / seasonal_____ o o o
Animals_____ o o o
Food_____ o o o
Other_____ o o o

	Yes	No	DK
Heart murmur	o	o	o
Mitral valve prolapse	o	o	o
Artificial heart valves	o	o	o
Rheumatic fever	o	o	o
Cardiovascular disease	o	o	o
Angina	o	o	o
Arteriosclerosis	o	o	o
Congestive heart failure	o	o	o
Coronary artery disease	o	o	o
Damaged heart valves	o	o	o
Heart attack	o	o	o
Low blood pressure	o	o	o
High blood pressure	o	o	o
Congenital heart defects	o	o	o
Pacemaker	o	o	o
Rheumatic heart disease	o	o	o
Abnormal bleeding	o	o	o
Anemia	o	o	o
Blood transfusion	o	o	o
If yes, date:			
Hemophilia	o	o	o
AIDS or HIV infection	o	o	o
Arthritis	o	o	o
Autoimmune disease	o	o	o
Rheumatoid arthritis	o	o	o
Systemic lupus erythematosus	o	o	o
Asthma	o	o	o
Bronchitis	o	o	o
Emphysema	o	o	o
Sinus trouble	o	o	o
Tuberculosis	o	o	o
Cancer/Chemotherapy/ Radiation treatment	o	o	o
Chest pain upon exertion	o	o	o
Chronic pain	o	o	o
Diabetes Type I or II	o	o	o
Eating disorder	o	o	o
Malnutrition	o	o	o
Gastrointestinal disease	o	o	o
G.E. Reflux/Persistent heartburn	o	o	o
Ulcers	o	o	o
Thyroid problems	o	o	o
Stroke	o	o	o
Glaucoma	o	o	o
Hepatitis, jaundice or liver disease	o	o	o
Epilepsy	o	o	o
Fainting spells or seizures	o	o	o
Neurological disorders	o	o	o
If yes, specify:			
Sleep disorder	o	o	o
Mental health disorders	o	o	o
If yes, specify:			
Recurrent infections	o	o	o
Type of infection:			
Kidney problems	o	o	o
Night sweats	o	o	o
Osteoporosis	o	o	o
Persistent swollen glands in neck	o	o	o
Severe headaches/ Migraines	o	o	o
Severe of rapid weight loss	o	o	o
Sexually transmitted disease	o	o	o
Excessive urination	o	o	o

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ..... o o o
Name of physician or dentist making recommendation:_____ Phone: (_____)_____
Do you have any disease, condition, or problem not listed above that you think I should know about? ..... o o o
Please explain: _____

Anything else you want to tell us about your medical condition:

CONSENT TREATMENT FORM

The undersigned authorizes Dr. Claussen to take CT Scans / Panos, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Claussen to make a thorough diagnosis of the patient's dental needs. I also authorize Dr. Claussen to perform any and all forms of treatment and medication that may be indicated in connection with treatment plan as well as authorize consent for Dr. Claussen to employ such assistance as consulting with other doctors regarding overall treatment. I agree to use the anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

PATIENT_____DATE_____

PARENT/RESPONSIBLE PARTY_____

RELATION TO PATIENT_____

FINANCIAL RESPONSIBILITY FORM

If you have dental insurance, we will file the claims for you, as a complimentary service. It is very important that the correct insurance information is provided at the time of the patient's appointment. While we do our best to verify dental benefits prior to your first appointment, this does not guarantee coverage or payments to Oral Surgery & Dental Implant Center.

We will provide you with a verbal **ESTIMATE** of your out of pocket expense for any treatment planned by the doctor. However, please understand that these are strictly estimates and are not a guarantee that your insurance company will reimburse us according to these estimates.

Please note that any difference in payment from your insurance company and your account balance is your responsibility. While the filing of insurance claims is a courtesy that we extend to all of our patients, all charges are your responsibility from the date the services are rendered.

All insurance balances remaining unpaid after 60 days from the date of service becomes the immediate responsibility of the patient and/or account holder. Payment for treatment is due at the time services are provided. If a payment has not been received on the account during the 90 days, the account risks being sent to a collection agency.

I acknowledge having read this Financial Responsibility Form in its entirety and agreed to be bound by all terms and conditions herein.

_____ _____/_____/_____
PATIENT NAME (print) DATE

_____
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY (GUARANTOR) / RELATIONSHIP

_____ _____ _____
Guarantor / Printed Name Social Security # Phone #

_____ _____ _____
Address State Zip Code

HIPAA COMPLIANCE

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) this practice may use your personal health information for the purposes of treatment, payment, or healthcare operations only. The specific uses and disclosures that we intend to make are described
in our Privacy Policy. You have the right to review our Privacy Policy prior to signing this consent form. You may request restrictions on the uses and disclosures described in the privacy policy by describing the requested restrictions in the "Restriction Request" section of this form.

CONSENT SECTION

I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment, and healthcare operations. My signature below indicates that I have been given the opportunity to review the Privacy Policy of Eric R. Claussen, DMD, Oral Surgery & Dental Implant Center.

Please allow the following person(s) to obtain my healthcare information. (If none, please write NONE)

_____ _____

_____ _____

_____ _____

Patient Signature Date

Eric R. Claussen, DMD, PA - OFFICE POLICY

Thank you for choosing Dr. Eric Claussen. Our policies are listed below for your careful review. These policies are intended to make your visit with us as pleasant as possible, and enable our staff to provide the highest quality of care.

Please read all information and acknowledge by signing below.

1. We ask that you present your insurance card at each visit. It is your responsibility to provide us with the correct information to bill your insurance.
2. If you have a change of address or telephone number(s), please notify our office immediately.
3. Your insurance coverage is a contract between you and the insurance company. When we verify your coverage, any amount quoted to us by the insurance company is **not a guarantee of payment.** It is very important that you understand the provisions of your policy.
4. We will collect your deductible, co-payment, or charge for a non-covered service at the time of your visit.
5. If your insurance denies our charges, or does not pay us in a timely manner, or if your account becomes delinquent (60 days) we reserve the right to refer your account to a collection agency to be reported to the credit bureau.
6. No show or missed appointments - We understand there may be times when you are unable to keep an appointment, but we ask the courtesy of a phone call to cancel an appointment by you. If two appointments are missed without cancellation, you will be charged a $25.00 fee. If three appointments are missed, you will be dismissed from the practice for non-compliance.
7. Any balances on your account need to be paid in full before you will be seen again unless a payment arrangement has been made with billing personnel.
8. Returned checks will be subject to a Non-Sufficient Fund Fee of $35.00.

9. Please remember, whether you have insurance or not, you are ultimately financially responsible for payment of your charges. If you have any questions regarding our financial policy, please contact our office.

Thank you very much for reading and adhering to our policies.

I have read and have a full understanding of the financial policy of Eric R. Claussen, Oral Surgery & Dental Implant Center.

Signature:_____ **Date:**_____