Heidi Sprowls DDS

PATIENT REGISTRATION

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

Preferred Name: _____

Patient Is: ☐ Policy Holder

☐ Responsible Party

Responsible Party (if someone other than the patient)

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

Address: _____ Address 2: _____

City: _____ State / Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____ Ext: _____

Birth Date: _____ Age: _____ 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: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____ Ext: _____

Sex: ◯ Male ◯ Female Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Seperated ◯ Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic: _____

Email: _____ ☐ I would like to receive correspondances via email.

Employment Status: ◯ Full Time ◯ Part Time ◯ Retired

Student Status: ◯ Full Time ◯ Part Time

Emergency Contact Person: _____ Phone: _____

Other Family Members Seen By Us: _____

Whom May We Thank For Referring You: _____

Additional Comments:

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: _____

Subscriber ID#: _____ Group #: _____ Ins. Phone #: _____

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: _____

Subscriber ID#: _____ Group #: _____ Ins. Phone #: _____

Heidi Sprowls DDS

MEDICAL HISTORY

Patient Name: _____ Birth Date: _____

Although dental personnel primarily treat the area in an 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. Than you for answering the following questions.

Are you under a physician's care now? ◯Yes ◯No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ◯Yes ◯No If yes, please explain: _____

Have you ever had a serious head or neck injury? ◯Yes ◯No If yes, please explain: _____

Are you taking any medication, pills or drugs? ◯Yes ◯No If yes, please explain: _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯Yes ◯No _____

Are you on a special diet? ◯Yes ◯No _____

Do you use tobacco? ◯Yes ◯No

Do you use controlled substances? ◯ Yes ◯ No

Women: Are you:

Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

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

☐ Other If yes, please explain: _____

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 Problem ◯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 above? ◯ Yes ◯ No _____

List of medication (prescription and over-the-counter), vitamins, minerals, and herbal remedies you are currently taking: _____

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 of Guardian: _____ Date: _____

Insurance

Heidi Sprowls DDS is committed to helping our patients maximize their benefits. As you may be aware, medical and dental insurance are becoming increasingly complex. We are always available to answer your questions, however, your insurance policy is a contract between you and your insurance company.

As a medical provider, we are not party to that agreement. The patient portion (co-payment) of your bill must be paid at the time of service. We ask our patients to provide us with complete dental insurance information. As a service to our patients we will bill insurance companies for services and allow 45 days to render payment in full. After 60 days, you are responsible for the entire balance which is due in full upon request.

Insurance policies vary considerably; therefore we estimate your coverage in good faith but cannot guarantee coverage or payment amounts by your insurance company. Our office can only provide estimates and not exact amounts.

If you have any questions please do not hesitate to contact our office at 937.434.1151 or email

We look forward to seeing you!

Heidi Sprowls DDS

Appointment Policy

Our staff at Heidi Sprowls DDDS is committed to providing the highest quality of dental care and services for our patients. Dental procedures require preparation and planning. This includes appropriate staffing, treatment room availability and material preparation at specific times during our work day. We reserve specific time blocks in an attempt to meet patient schedules and the urgency of the dental need. If you have made an appointment with us, that time has been reserved exclusively for you and we have prepared in advance for your visit. Please be advised of the following requirements:

- We require 48 hours' notice for cancellation of a scheduled appointment
- A cancellation fee of $40.00 will be added for all missed or cancelled appointments with less than 48 hours' notice. Appointments longer than 60 minutes will result in a higher fee
- If there are three missed or cancelled appointments without 48 hours' notice appointments in a year time frame, we reserve the right to not schedule any further appointments or to require a deposit in order to schedule a future appointment.
- Family emergencies will be taken into consideration

_____ _____

Signature of patient (or responsible party) Date

Patient Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1995 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have the right to read the *Notice of Privacy Practices* before deciding whether to sign this Consent.

This office reserves the right to change the privacy practices as described in the *Notice of Privacy Practices*. If it is changed, a revised *Notice of Privacy Practices* will be issued.

I have the right to request that you place additional restrictions on the use or disclosure of my health information. You are not required to agree to these additional restrictions, but if you do, you will abide by our agreement (except in an emergency).

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

Financial Policy

Your co-payment is due at the time services are rendered. Heidi Sprowls DDS offers the following payment options:

- Cash, Credit (all major credit cards accepted), Care Credit, Money Order and Checks (A $35.00 charge will be added to the account for any NSF check returns)
- On qualified balances we may offer a Three (3) month payment plan. In order to qualify for this option, a credit card would need to be placed on file to be charged each month.
- Office Policy is to charge 1.5% monthly fee with the minimum $2.00 to all accounts that are over 60 days past due.
- We do our best to minimize the use of outside sources to aid in the collection of delinquent balances. Any account 60 days past due may be sent to a collections office after all efforts Heidi Sprowls DDS have been exhausted. The minimum fee charged for your account being sent to collections is $50.00

Our financial arrangements are based on an open and honest discussion of recommended treatment options, respective fees and our patient's financial capabilities.

Financial Consent

The patient (or person with financial responsibility for the account) agrees to be fully responsible for total payment of treatment performed in this office.

I fully understand and agree to all terms in this office policy.

Names of patients that are responsibility of the signer (please print):

_____

_____

_____ _____

Signature of patient (or if minor, person responsible) Date