Capstone Dental New Patient Registration

PATIENT INFORMATION

Patient Name Last _____ First _____ MI ___ Nickname _____
Residence Street _____ City _____ State _____ Zip _____
Mailing Address Street _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Mobile Phone _____
Sex: M / F Date of birth: _____ Married: Y / N email: _____
If student: Student status FT PT School _____ City/State _____ Zip _____
Employer _____ Occupation _____

Whom may we thank for referring you to our office: _____

SPOUSE/PARENT/GUARDIAN INFORMATION

Name Last _____ First _____ MI _____ Married: Y / N
Residence Street _____ City _____ State _____ Zip _____
Mailing Address Street _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Mobile Phone _____
Date of birth _____ Relationship to patient _____
Employer _____ Occupation _____

DENTAL INSURANCE (PRIMARY CARRIER)
Insured's Name _____
Insurance Company _____
Insured's Employer _____
Insured's Social Security # _____
Subscriber ID # if not SS# _____
Group Number _____
Insurance Co Phone Number _____

SECONDARY (Complete if you have dual coverage)
Insured's Name _____
Insurance Company _____
Insured's Employer _____
Insured's Social Security # _____
Subscriber ID # if not SS# _____
Group Number _____
Insurance Co Phone Number _____

MEDICAL HISTORY: This information will be kept confidential. Circle if any of these apply to you, now or in the past:

Heart Attack or Heart Disease / Angina / Murmur / Mitral Valve Prolapse / Rheumatic Fever / High Blood Pressure
Artificial Valve / Pacemaker / Artificial Joints / Diabetes / Anemia / Hemophilia / Bleeding Disorder / Ulcer
Blood Transfusion / Kidney Problems / Liver Problem / Thyroid disease / Hepatitis A, B or C / Glaucoma / Epilepsy
Seizures / Stroke / Tuberculosis (TB) / Asthma / Allergies / Chemo or Radiation Therapy / Arthritis / AIDS or HIV
Alcoholism / Drug Addiction / Psychiatric Treatment Do you smoke: Y / N

Are you allergic to or have you had any problems with the following:
Penicillin / Erythromycin / Codeine / Aspirin / Motrin or Advil / Local Anesthetic / Nitrous Oxide
If yes, Describe the problem _____
Allergy to other medications? _____
Current Medications: _____ Are you Pregnant: Y / N

Last Complete Dental Exam _____ X-Rays _____
Reason for your visit today _____
What would you change about your smile _____
Do you fear coming to the dentist Y / N If so, why? _____

Circle if you have had: Gum treatments / Bleeding gums / Problem with Jaw (TMJ) / Clenching
Grinding / Sensitivity / Denture / Partials / Braces / Implant / Periodontal Disease
How Often do you floss _____ Manual or electric toothbrush _____

_____

Patient Signature Date Doc Signature/Date

Greg Kempers, DDS
Capstone Dental

Thank you for choosing the office of Dr. Greg Kempers. We are dedicated to providing you with the very best quality of dental care so that you may have a positive experience.

Insurance _____(Initial)
Your insurance policy is a contract between you and your insurance company. We will file your claim for you at no charge; however, deductibles and co-insurance costs are paid at the time of service. Whatever insurance doesn't cover becomes the responsibility of the patient.

Appointments _____(Initial)
We are pleased to offer text/email/phone reminders. Because your appointment time is scheduled especially for you, we ask that you give a 48 hr business notice if you need to cancel or reschedule an appointment. If you cancel last minute or fail to show for an appointment we may charge you a cancellation fee: 1st occurrence - no charge; 2nd occurrence - $75; 3rd occurrence - $125.

Financial Policy _____(Initial)
Payment is due at the time services are rendered. We accept all major credit cards and cash. Financing is available through outside agencies such as CareCredit. A finance charge will be assessed monthly on all overdue balances. We are willing to work out special financial arrangements if facing a financial hardship but in the event the account become delinquent we will submit the account to collections. If submitted to collections, the patient will be assessed a 30% charge of the account balance and will be responsible for all attorney fees.

HIPAA/ Privacy Policy _____(Initial)
We value the privacy of your information. In accordance with the HIPAA Privacy Act, we will apply the appropriate measures to keep your information secure. A copy of our privacy policy is available upon request.

I acknowledge that I have read and agree to this office's notice of Privacy Practices/ HIPAA, financial, insurance and appointment policies.

_____ _____
Signature **Date**