TIME 12:00 PM

DATE 9/28/2022

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: _____

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.

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 _____

Previous Dentist _____

Emergency Contact _____

Emergency Contact # _____

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: _____

Time 4:23 PM

Cory B. Sellers D.D.S., M.S.D.
Dr Cory Sellers

Date 9/26/2022

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and 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, c

Are you under a physician's care now?	○Yes ○No	If yes	
Have you ever been hospitalized or had a major operation?	○Yes ○No	If yes	
Have you ever had a serious head or neck injury?	○Yes ○No	If yes	
Do you take, or have you taken, Phen-Fen or Redux?	○Yes ○No	If yes	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○Yes ○No	If yes	
Are you on a special diet?	○Yes ○No		
Do you use tobacco?	○Yes ○No		
Have you been told you need pre-med or an antibiotic for dental visits?	○Yes ○No	If yes	
Are you taking any medications, pills, or drugs?	○Yes ○No		

List of Medications

Women: Are you...

☐Pregnant/Trying to get pregnant? ☐Nursing? ☐Taking oral contraceptives?

Are you allergic to any of the following?

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

Do you use controlled substances?	○Yes ○No	If yes	
Other?	☐	If yes	

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 Problems	○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	If yes	

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 or Guardian:

X

Date:_____

DCD Dayton Comprehensive Dentistry

Office Policy – Financial Agreement

We are committed to deliver comprehensive dental care to our patients, using state-of-the art technology and the highest quality materials available today. We always recommend treatment based upon individual needs, not based on insurance coverage, which may be inadequate with some dental plans. We believe dental insurance is a benefit used to assist the patient, not dictate necessary treatment. **This agreement is to inform our patients of the financial policies currently in effect for Dayton Comprehensive Dentistry.**

Dental Insurance

- Knowledge of covered benefits as well as amounts, limitations, exclusions, waiting periods, etc. are exclusively the patient's responsibility.
- Our office will provide all necessary documentation to support recommended treatment plans, in order to prove rationale and reasons for medical necessity.
- Completing insurance forms for our patients is a courtesy offered to help facilitate timely payment from insurance companies. This process does not eliminate patient's financial obligation. We are happy to help submit dental claims on behalf of our patients, but we do not accept responsibility for the outcome of the transaction.
- Assignments of benefits from insurance companies are accepted by our office, but the terms of the agreement regarding dental benefits are between the insured, the employer, and the insurer (insurance company). ***Although we may estimate insurance benefits, we are not responsible for their accuracy.***
- Not all dental services provided in our office represent covered benefits, ***therefore payment for treatment cannot be guaranteed***. If a claim is denied, full payment becomes the patient's responsibility. Accepting our service indicates the patient's acceptance of such responsibility.
- **Our practice will not enter into a dispute with any insurance company over claims. Once complete documentation is submitted to the insurance carrier, it is the responsibility of the insured to resolve any type of dispute over payments to be rendered to our office.**
- Insurance payments are typically received within 30-60 business days from the time of billing. **All charges not paid by an insurance company become the patient's responsibility regardless of reason for nonpayment.**

Payment for treatment rendered

- **All charges incurred for any treatment provided in our office are the patient's responsibility regardless of insurance coverage.**
- The co-payment is the **ESTIMATED** portion of the cost of the treatment not honored by the dental insurance.
- Timely payment of the financial responsibility helps maintain administrative cost and dental fees low.
- As we work with our patients to deliver optimal oral and dental health, we ask that the estimated co-payment for treatment be paid at time of service.
- Our practice accepts cash, personal check, MasterCard, Visa, Discover, and American Express.
- The estimated co-payment may be adjusted after completion of treatment, depending upon the final reconciliation of insurance payments.

DCD Dayton Comprehensive Dentistry

Payment Plan

- We understand temporary financial problems which may affect timely payment of balances. In those situations, we encourage you to immediately reach out to our office so we may discuss available alternatives in managing your account.
- We are pleased to offer Care Credit, a financial company which helps devise individual payment plans. This allows completion of dental work without delay and helps fulfill financial responsibility in monthly installments. Applications may be submitted in the office or online at www.carecredit.com.

Overdue balances

- Accounts with unpaid balances past 90 days are submitted to a collection agency.
- Cost incurred in debt collections include: additional interest of 21% on the unpaid balance from the last date of services, attorney fees, court fees and any other fees associated with debt collections.
- Above referenced expenses are the patient's responsibility.

Dental records

- Copy of your dental records or radiographs will be provided upon written request, for a nominal fee.

Cancellations and rescheduling dental appointments

- Prior notice of 24-business hours is required to cancel and reschedule existing appointments.
- A $57 charge will be added to the patient's account for missed appointments or rescheduled less than 24 hours out. $100 fee will apply for scheduled services totaling more than $500.
- **ALL SATURDAY APPOINTMENTS NOT CANCELED AT LEAST 24 HOURS IN ADVANCE WILL INCUR A $100.00 CANCELATION FEE REGARDLESS OF THE REASON.**
- **DCD Springboro does reserve the right to cancel any appointment that has not be *confirmed by the patient at least 24 hours in advance.***

Please read and initial below

____I understand it is my responsibility to know the terms of my dental insurance.

____I read the above stipulations and agree to pay Dayton Compressive Dentistry in full without regard to insurance coverage, whether I sign as a responsible party or as a patient.

____I agree to pay collection fees as stated above should these means of collections become required.

____I am providing this office with complete and accurate billing information.

____I will pay all co-pays and outstanding patient balances as they become due.

_____ _____ _____

Patient name (print) Patient/Guardian signature Date

DCD Dayton Comprehensive Dentistry

Notice of Privacy Practices

I have received and understand this practice's Notice of Privacy Practices. 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 my request.

I authorize Dayton Comprehensive Dentistry to disclose account information; not limited to diagnosis, records, claims and billing, to the name(s) listed below.

_____

_____ _____ _____

Patient name (print) Patient/Guardian signature Date