TIME 09:36 AM

DATE 7/23/2015

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:

Home Phone: Work Phone: Ext: Cellular: Pager:

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 9:34 AM

Rocky Mountain Family Dental

Eaglesoft Medical History

Date 7/23/2015

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, 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 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

Are you taking any medications, pills, or drugs? ○ 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

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 ○ Yes ○ No If yes

Comments:

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:_____

DENTAL HISTORY

Name _____ Nickname _____ Age _____
Referred by _____ How would you rate the condition of your mouth? ☐Excellent ☐Good ☐Fair ☐Poor
Previous Dentist _____ How long have you been a patient? _____ Months/Years
Date of most recent dental exam ____/____/____ Date of most recent x-rays ____/____/____
Date of most recent treatment (other than a cleaning) ____/____/____
I routinely see my dentist every: ☐3 mo. ☐4 mo. ☐6 mo. ☐12 mo. ☐Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

		YES	NO
PERSONAL HISTORY			
1.	Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____]	☐	☐
2.	Have you had an unfavorable dental experience?	☐	☐
3.	Have you ever had complications from past dental treatment?	☐	☐
4.	Have you ever had trouble getting numb or had any reactions to local anesthetic?	☐	☐
5.	Did you ever have braces, orthodontic treatment or had your bite adjusted?	☐	☐
6.	Have you had any teeth removed or missing teeth that never developed?	☐	☐
GUM AND BONE			
7.	Do your gums bleed or are they painful when brushing or flossing?	☐	☐
8.	Have you ever been treated for gum disease or been told you have lost bone around your teeth?	☐	☐
9.	Have you ever noticed an unpleasant taste or odor in your mouth?	☐	☐
10.	Is there anyone with a history of periodontal disease in your family?	☐	☐
11.	Have you ever experienced gum recession?	☐	☐
12.	Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?	☐	☐
13.	Have you experienced a burning or painful sensation in your mouth not related to your teeth?	☐	☐
TOOTH STRUCTURE			
14.	Have you had any cavities within the past 3 years?	☐	☐
15.	Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?	☐	☐
16.	Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?	☐	☐
17.	Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth?	☐	☐
18.	Do you have grooves or notches on your teeth near the gum line?	☐	☐
19.	Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?	☐	☐
20.	Do you frequently get food caught between any teeth?	☐	☐
BITE AND JAW JOINT			
21.	Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	☐	☐
22.	Do you feel like your lower jaw is being pushed back when you bite your teeth together?	☐	☐
23.	Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?	☐	☐
24.	Have your teeth changed in the last 5 years, become shorter, thinner or worn?	☐	☐
25.	Are your teeth becoming more crooked, crowded, or overlapped?	☐	☐
26.	Are your teeth developing spaces or becoming more loose?	☐	☐
27.	Do you have more than one bite, squeeze, or shift your jaw to make your teeth fit together?	☐	☐
28.	Do you place your tongue between your teeth or close your teeth against your tongue?	☐	☐
29.	Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	☐	☐
30.	Do you clench your teeth in the daytime or make them sore?	☐	☐
31.	Do you have any problems with sleep (i.e. restlessness), wake up with a headache or an awareness of your teeth?	☐	☐
32.	Do you wear or have you ever worn a bite appliance?	☐	☐
SMILE CHARACTERISTICS			
33.	Is there anything about the appearance of your teeth that you would like to change?	☐	☐
34.	Have you ever whitened (bleached) your teeth?	☐	☐
35.	Have you felt uncomfortable or self conscious about the appearance of your teeth?	☐	☐
36.	Have you been disappointed with the appearance of previous dental work?	☐	☐

Patient's Signature _____ Date _____
Doctor's Signature _____ Date _____

FOR YOUR CONVENIENCE THE FOLLOWING PROGRAMS ARE AVAILABLE TO HELP PLAN YOUR DENTAL INVESTMENT:

☐ Plan 1 Payment in full at the time of service. ALL emergency appointments are payment at the time of service.

☐ Plan 2 Submit to dental insurance. Patient will immediately be responsible for the balance NOT paid by insurance. **(CO-PAYMENTS DUE AT TIME OF SERVICE!)**

☐ Plan 3 Equality Care. **Please note-for ALL EQUALITY CARE PATIENTS,** if there is a procedure code that Equality Care does **NOT** pay on, the patient is responsible for the charge in full. **NO EXCEPTIONS!**

☐ Other _____

The fee for services provided is a charge based upon what your dentist determines during the preliminary oral exam and x-rays. Because, even with x-rays, it is not always possible to diagnose every fault in teeth, it may later be determined that additional dental work is necessary. In such a case, you will be notified.

FEDERAL TRUTH IN LENDING STATEMENT FOR SERVICES RENDERED

1. Fee for services $ _____
2. Total Down Payment $ _____
3. Unpaid Balance $ _____
4. Amount Financed $ _____
5. Finance Charge $ _____
6. Finance Charge (Expressed as Annual percentage rate 21%) $ _____
7. Total Payment Due (4 plus 5) $ _____
8. Total Charge $ _____

Total payment due (7 above) is payable to Dr Laci Rector, in _____ monthly payments of $ _____. The first installment is payable on _____, and each subsequent payment is due on the same of each consecutive month until paid in full. In the event any such installment or payment shall be more than 10 days late, the entire balance shall become immediately due. In the event the patient does not make payments as set forth herein, the patient agrees to pay all costs of collection agencies, attorney fees, court costs and office time and expense in attempting collection. The undersigned acknowledges receipt of dental services dental services by Laci D. Rector, DDS, PC. Both parties agree that there will be no interest, finance or carrying charge if the account is paid in full within sixty days from the date the service is performed, the entire debt being due and payable at the time of such service. The patient acknowledges that he (she) will be charged 1.75 percent per month Finance Charge (Annual Percentage Rate 21%) on the unpaid balance after the sixty-first day has expired and until the account is paid in full.

Both parties acknowledge that they have read this agreement and that the terms thereof are acceptable and agreeable to each.

DATED this _____day of _____, 20____.

_____

SIGNATURE OF PATIENT,
PARENT IF PATIENT IS A MINOR

_____

LACI D. RECTOR, DDS, PC

ROCKY MOUNTAIN
Family Dental

Laci D. Rector D.D.S., P.C. 2910 Big Horn Ave., Suite A Cody, WY 82414

(307)-587-5588

Failed Appointment/ Cancellation Policy

We strive to render excellent dental care to you and the rest of our patients. In an attempt to be consistent with this, we have a **Failed Appointment/Cancellation Policy.** When an appointment is scheduled, that time has been set aside for you and when it is missed, that time cannot be used to treat another patient.

Our policy is as follows:
We require that you give our office **24 hours** notice in the event that you need to reschedule your appointment. This allows for other patients to be scheduled into that appointment. If you miss an appointment without contacting our office within the required time, this is considered a missed appointment. A fee of $50.00 will be charged to you; this fee cannot be billed to your insurance company and will be your direct responsibility. No future appointments can be scheduled without the payment of this fee. Additionally, if a patient is more than **15 minutes** late without prior notice for a scheduled appointment, we will consider this a missed appointment and the **$50.00 cancellation fee** will be charged. We understand that situations do arise last minute, and there will be exceptions to this policy in those cases.

If you are a new patient and you fail your first appointment, this will result in having to make a $100.00 non-refundable deposit to reschedule your appointment. After that, if you make your appointment, the deposit will go towards that visit and/or future treatment.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have. We thank you for your patronage.

I have read and understand the Appointment Cancellation Policy of the practice and I agree to its terms.

_____ _____

Signature of Patient Date

ROCKY MOUNTAIN
Family Dental

Laci D. Rector D.D.S., P.C. **2910 Big Horn Ave., Suite A** **Cody, WY 82414**

(307)-587-5588

In the event that my dental insurance pays more than my estimated co-pay in the amount of: (please circle one)

$0-$25 $26-50 $51-$100

I would like to apply the balance as follows: (Please mark one)

_____ Refund Check (mailed to me)

_____ Credit on my account (for future use)

If the overpayment is more than the amount circled, we will automatically mail you a refund check.

Signature_____ Date_____