

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

Section 3

Employment Status: Full Time Part Time Retired

Student Status: Full Time Part Time

Medicaid ID: _____

Prof. Dentist: _____

Employer ID: _____

Prof. Pharmacy: _____

Carrier ID: _____

Prof. Hyg: _____

Referred By _____

Previous Dentist _____

Emergency Contact _____

Emergency Contact # _____

Employer _____

Job Type _____

Note _____

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: _____

Dental Records Release Form

By signing this form I authorize the staff of Sunrise Dental to release my confidential information, or the staff of the listed Dental office by releasing a copy of my records to the physician/person/facility/entity listed below.

Release my protected dental information, *this to include all records that are legally mine* to/or from the following physician/person/facility/entity:

Dental Office Transferring From & Phone Number: _____

Dental Office Transferring To: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Email: _____

Patient Name and DOB:

Additional Family Members Transferring and DOB:

Please send: Current within the last 12 months unless noted otherwise

Chart Notes X-Rays Perio Charting

The reason for release of information is as follows:

Signature of Patient or Representative

Date

***** SUNRISE DENTAL STAFF ONLY *****

Date Request Faxed to other Office

Sunrise Dental Employee Faxing Release

SUNRISE DENTAL of LONGVIEW

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

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? | <input type="radio"/> Yes | <input type="radio"/> No | If yes, please explain: _____ |
| Have you ever been hospitalized or had a major operation? | <input type="radio"/> Yes | <input type="radio"/> No | If yes, please explain: _____ |
| Have you ever had a serious head or neck injury? | <input type="radio"/> Yes | <input type="radio"/> No | If yes, please explain: _____ |
| Are you taking any medications, pills, or drugs? | <input type="radio"/> Yes | <input type="radio"/> No | If yes, please explain: _____ |
| Do you take, or have you taken, Fosamax or Bisphosphonate? | <input type="radio"/> Yes | <input type="radio"/> No | _____ |
| Are you on a special diet? | <input type="radio"/> Yes | <input type="radio"/> No | _____ |
| Do you use tobacco? | <input type="radio"/> Yes | <input type="radio"/> No | |
| Do you use controlled substances? | <input type="radio"/> Yes | <input type="radio"/> No | |

Women: Are you
 Pregnant or trying to get pregnant? Nursing?
 Taking oral contraception?

Are you allergic to any of the following?

- Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Sulfa
 Other If yes, please explain: _____

Do you have, or have you had, any of the following?

- | | | | | |
|---|---|--|--|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Cold Sores/ Fever Blisters | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Heart Pace Maker | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Easily Winded | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Swelling of Limbs |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Parathyroid Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Radiation Treatments | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Herpes | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Renal Dialysis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Cough | <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Yellow Jaundice |

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

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 my patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature or Patient, Parent or Guardian _____ Date _____

SUNRISE DENTAL of LONGVIEW

Office Policy

Dear Patients,

Thank you for choosing Sunrise Dental as your family dental provider. We look forward to providing you high quality dental care at an affordable price.

When scheduling your appointments, we are making a commitment to you. Please remember that we have reserved a special time for you. If you find a need to reschedule your appointment, we ask for a minimum of 48 hours' notice. ***Failed appointments and cancelled appointments without 48 hours' notice are subject to an \$85.00 fee per hour your appointment time is scheduled for.***

We bill your insurance as a courtesy to you. If any amounts are denied or not covered, the ***balance owing is your responsibility.*** Your estimated patient portion for services is based upon the information provided by your insurance company, and is expected on the day treatment is rendered. We will give you an estimated treatment plan based on your insurance information provided to us before any treatment is started.

Patient portion for services are due at the time treatment is rendered. Please bring your payment with you.

I declare that I am not a recipient of state assisted insurance, including but not limited to, DSHS.

Patient acknowledges in consideration for dental services to be rendered any outstanding debt to our office will not be included in any bankruptcy petition.

Unfortunately, we do not have the resources to maintain adequate supervision of children. Please refrain from bringing unattended/unscheduled children.

Thank you again for your understanding and care with helping to keep our facilities safe and clean and helping us provide you with the best possible dental care.

Patient Signature: _____ Date _____



Statement of Privacy Practices Sunrise Dental

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principal concept of our practice. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect your rights.

Protecting your personal health care information

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the State of Washington. This includes issues relating to your treatment, payment, and our dental care operations. Your personal health information will never be otherwise given to anyone, even family members, without your written consent. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to all former, current and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

Collecting protected health information

We will only request personal information needed to provide our standard of quality dental care, implement payment activities, conduct normal dental practice operations, and comply with the law. This may include your name, address, telephone numbers, social security number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

Disclosure of your protected health information

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and government officials under certain circumstances. We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines, and postcards.

Patient rights

You have the right to request copies of your healthcare information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. All such requests must be in writing. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately.

We thank you for being a patient at our office. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.