BOZEMAN FAMILY DENTISTRY

PATIENT REGISTRATION

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

Preferred Name: _____

How did you hear about us? ☐ Current Patient*: _____ ☐ Newspaper

☐ Social Media ☐ Other: _____

Let us know who referred you so they can be entered into our monthly **Referral Thank You Raffle!*

Patient is: ☐ Responsible Party* ☐ Policy Holder

***Responsible Party: (if someone other than the patient or skip to next section)**

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

Address: _____ Address 2: _____

City _____ State _____ Zip: _____

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

Birth date: ____/____/_____ Social Security #: _____ OR Drivers Lic#: _____

○ Responsible Party is Policy Holder for Patient ○ Primary Policy Holder ○ Secondary Policy Holder

Patient Information:

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

Address: _____ Address 2: _____

City _____ State _____ Zip: _____

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

Sex: ○ Female ○ Male Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth date: ____/____/_____ Social Security #: _____ **OR** Drivers Lic#: _____

E-mail: _____ ← We won't spam you!

Employment Status: ○ Full Time ○ Part Time ○ Self Employed ○ Retired ○ Unemployed

Primary Insurance Information:

Name of Insured: _____ Relationship to Insured: ○Self ○Spouse ○Child ○ Other

Insured Social Security #: _____ Insured Birth date: ____/____/_____

Employer: _____

Group #: _____

ID #: _____

Insurance Company: _____

Address: _____

CITY: ST: ZIP:

Time 8:16 AM

Bozeman Family Dentistry

Eaglesoft Medical History

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
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	
Do you use controlled substances?	◯ Yes ◯ No	If yes

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

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

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: _____

Bozeman Family Dentistry

(406)577-2015

Acknowledgement

I, _____, hereby acknowledge that I have received and reviewed a copy of Bozeman Family Dentistry's *HIPAA Notice of Privacy Practices*.

I understand that Bozeman Family Dentistry's *HIPAA Notice of Privacy Practices* may change periodically and that I am entitled to receive a copy of Bozeman Family Dentistry's revised *HIPAA Notice of Privacy Practices* upon request.

I understand that, if I have questions about Bozeman Family Dentistry's *HIPAA Notice of Privacy Practices*, I may contact Ashley Bowen at:

(406)577-2015.

ashley@bozemanfamilydentistry.com.

I understand that it is my right to refuse to sign this Acknowledgement should I so choose, and that Bozeman Family Dentistry will not refuse treatment to me if I refuse to sign this Acknowledgement.

I further understand that I may contact the Secretary of the U.S. Department of Health and Human Services should I have concerns regarding Bozeman Family Dentistry's privacy policies and procedures. For information on how to contact the U.S. Department of Health and Human Services, please ask Ashley Bowen noted above, for assistance.

_____	_____
Patient Signature	Date
_____	_____
Signature of Personal Representative	Print Name of Personal Representative
	_____
	Relationship of Personal Representative to Patient

BOZEMAN
FAMILY DENTISTRY

Financial Policy-Please read and sign

At Bozeman Family Dentistry we have made the decision that we can better serve our patients by being out of network providers. We have made this decision in an effort to keep the cost of our services low. What this means is that we work with insurance companies a little bit different than other dental practices. This is meant to inform you of how we plan to work with you, and your insurance plan and company.

Because we are considered "out of network" we ask for payment of services at the time the service is rendered. In some cases, and with larger treatment plans we allow for payments to be made on an account however this is on a case by case basis. Once treatment is done and the full payment is made we electronically submit the claim to your insurance company and they will reimburse you directly. Periodically insurance companies send your reimbursement check to our office and if this is the case we will reimburse you from our office.

Remember, the insurance that you have is yours. We do not have any control over when they choose to reimburse, what they reimburse or fees that they may apply. The information that you provide is what is used to submit your claim and that is why it is important that you put ALL the CORRECT dental information down, failure to do so will result in a delay getting your reimbursement from your insurance company. If the information that you provide is incorrect we are not responsible for the length of time that your insurance company takes to reimburse you. You are responsible any fees incurred between you and your insurance company.

By signing this document I agree that if this account is not paid when due and Bozeman family Dentistry should retain an attorney or collection agency for collection, I agree to pay all the costs of collection including reasonable interest, reasonable attorney's fees (whether or not a lawsuit is filed) and reasonable collection agency fees in the amount of 50% of the balance due.

By signing this document I agree to and understand the financial policies stated above.

Patient: _____ Date: _____