PATIENT REGISTRATION FORM

Patient's Name (Last, First, MI): _____

Patient's Home Phone Number: _____ Cell Phone Number: _____

E-Mail Address: _____

Address: _____ Apt. # _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ Sex: M F Social Security Number: _____

Marital Status: [ ] Married [ ] Single [ ] Divorced [ ] Widowed

Patient's Employer: _____

Employment Status: [ ] Full time [ ] Part time [ ] Unemployed
[ ] Retired [ ] Student [ ] Other: _____

Responsible Party/Guarantor: _____ Relationship to Patient: _____

INSURANCE INFORMATION

Primary Insurance: _____

Patient is Subscriber/Policy Holder: Y N

Secondary Insurance: _____

Patient is Subscriber/Policy Holder: Y N

INSURED INFORMATION (IF OTHER THAN PATIENT) - We will request to scan your ID and insurance card.

Subscriber/ Policy Holder: _____ Relationship to Patient: _____

Address: _____

Identification Number: _____

Date of Birth: _____

His or Her Employer: _____ Work Phone Number: _____

Whom may we thank for referring you to our practice:

_____

Other family members seen here:

_____

Angela Manning DDS, PC reserves the right to charge a fee for any scheduled visits that are:

1. Cancelled with less than 24 business hours notice, which does not include weekends and holidays
2. Are missed without calling to cancel (no show)
3. If you are more than 15 minutes late, it is up to the discretion of the doctor/hygienist if there is time to still be seen. If there is not sufficient time for your appointment, you will be considered a missed appointment and will be charged.

Cancellation Fee schedule: New Patient $75.00; Established Patient: $50.00

Patient / Parent or Guardian Signature: _____ Date: _____

HEALTH HISTORY

Medical Information

Please list any **MEDICATIONS** you are currently taking, prescribed or over the counter:

Pre - Medication (if necessary): _____

Preferred **Pharmacy**: _____

Please list any surgeries you have had and include the month/year:

_____

_____

_____

Please indicate which medical condition applies to you:

Allergy-Latex		Diabetes		Pacemaker	
Allergy-Sulfa		Epilepsy/Seizures		Pregnancy	
Allergy-Penicillin		Hepatitis		Respiratory Disease	
Artificial Joints		High Blood Pressure		Stomach Issues	
Arthritis		HIV/AIDS		Sinus Issues	
Anxiety/Depression		Heart Attack/Disease		Sleep Disorder/ CPAP	
Asthma		Kidney Disease		Thyroid Disorder	
Cancer (Radiation)		Liver Disease			
		Low Blood Pressure			

Please list Primary Care Physician/Number as well as any other medical conditions (not listed above):

_____

_____

_____

_____

CONSENT FOR SERVICES

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

Patients with dental insurance understand that all dental services are charged directly to the insurance company. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services not covered by my insurance company, whether it be a co-payment or if my insurance company denies coverage for any reason. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney or collection fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

Patient / Parent or Guardian Signature: _____ Date: _____

PATIENT HIPPAA AWARENESS

With my permission, Dr. Angela Manning may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Dr. Angela Manning's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Dr. Angela Manning reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer.

With my permission, the office of Dr. Angela Manning may call my home or other designated locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results, among others.

With my permission, the office of Dr. Angela Manning may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements if they are marked Personal and or Confidential.

With my permission, the office of Dr. Angela Manning may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Dr. Angela Manning restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this, I am allowing Dr. Angela Manning to use and disclose my PHI for TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

Patient / Parent or Guardian Signature: _____ Date: _____