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

Child lives with ____________

Emerg. Contact # ____________

Emerg. Contact Name ____________

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: ____________

Josh McCormick, DDS, Inc.

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

Question	Yes	No	If yes
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

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

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

Condition		Condition		Condition		Condition	
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:__________

Insurance
Information Release Form

Policy Holder's Information

Policy Holder's Name	❑ Male ❑ Female	/ / Birthday	- - Social Security Number
Spouses Name	❑ Male ❑ Female	/ / Birthday	- - Social Security Number

Dependent's Name (last name if different than yours)

Dependent	❑ Male ❑ Female	/ / Birthday	- - Social Security Number
Dependent	❑ Male ❑Female	/ / Birthday	- - Social Security Number
Dependent	❑ Male ❑ Female	/ / Birthday	- - Social Security Number
Dependent	❑ Male ❑Female	/ / Birthday	- - Social Security Number

Insurance Information

Employer ____ Address ____, City ____, Zip ____ Phone Number ____

Insurance Company ____ Address ____, City ____, Zip ____ Phone Number ____

ID Number ____ Group Number ____ Plan Number ____

Secondary Insurance Information

Policy Holder's Name	❑ Male ❑ Female	/ / Birthday	- - Social Security Number

Employer ____ Address ____, City ____, Zip ____ Phone Number ____

Insurance Company ____ Address ____, City ____, Zip ____ Phone Number ____

ID Number ____ Group Number ____ Plan Number ____

Please Initial: ________ I authorize release of any information relating to my claim.

________ I authorize payment directly to Dr. Josh McCormick.

________ I understand that all fees not paid by insurance are my responsibility.

Print Patient Name ____ Patient or Policy Holder Signature ____ Date ____

Employee Signature ____

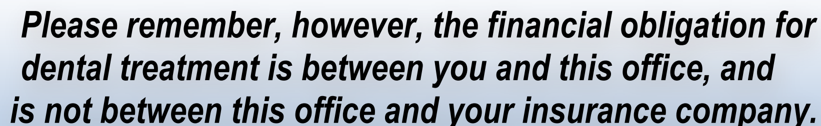
Note: If you have an insurance card, please give it to the receptionist so she can make a photocopy, which will help in speeding your insurance claim.

Our Policy
Regarding Dental Insurance

You are fortunate to have dental insurance, whether you have purchased it or your employer has provided it for you. Though your dental insurance is your responsibility we can help! We will go the extra mile to help you maximize your benefits. As a courtesy, we will help by filing your insurance forms, which will save you considerable time and trouble. We accept payments from most insurance companies, which reduces your immediate out-of-pocket expense.

Regardless of what we may calculate your insurance company to pay, it is only an estimate. Our estimate is based on limited information obtained from your insurance company. You must understand, we cannot forecast what they will pay.

We must stress that you are responsible for the total treatment fee. Your dental insurance is not designed to pay the entire cost of your treatment, but it is intended to help cover a certain portion of the cost. Better terms for dental insurance may be "dental assistance" or "dental benefits."



In order for us to obtain your insurance information for submiting your claim and/or discuss your situation directly with your insurance please complete the "Insurance Information Release Form" (attached) and return.

I have read and understand the above.

____________________	____________________	__________
Print Patient Name	Patient or Responsible Party Signature	Date

____

Employee Signature

Your Dental Needs

Your Name: ______________________________ Date: ______________

We place a high emphasis on helping you determine your present and future dental needs. Some things we will discuss during your first visit may be issues you have never considered before. Please check what best expresses how you feel about the following questions:

• Are you having any areas of concern?______________________________

• What do you think is the present state of your oral health?
____

• What do you already know about our office and what are your expectations?
____

• How healthy do you want us to get your mouth? (please circle)

The best it can be   Average   Don't really care

• Should you need treatment, at what point should we address it? (please circle)

When something isn't ideal   When something is worsening   When my tooth hurts or breaks

• What quality of dentistry do you want us to recommend? (please circle)

Ideal/the best   Average   Just patch it

• We have the ability to look at your mouth from three different perspectives. Please rank these in the order of most important to least important to you.

____As a general dentist   As a cosmetic dentist   As a functional dentist

• How do you feel about the appearance of your face and smile? ______________________________

• What would it take for you to trust us to be your dentist? ______________________________

• Tell us about your good dental experiences. ______________________________

• And the bad ones. ______________________________

• Has fear ever been an issue for you in a dental office? ______________________________

• What caused you to leave your last dental office? ______________________________

• Has time ever been a factor in getting your dental work done? ______________________________

• Has cost of dental treatment been a concern for you? ______________________________

• What can we do to help you with this? ______________________________

• Is there any additional information you would like us to know?______________________________

Josh McCormick, DDS
4455 Cowell Rd.
Concord, CA 94518
(925) 685-3043

Financial Agreement

Our goal is to provide the highest quality of dental care possible and to have clear communication of our financial policy.

All accounts are due and payable at time of service. If a procedure requires multiple appointments, payment is required in full at the time of the first appointment, unless other payment arrangements have been made. Parents not accompanying their child to an appointment must make prior arrangements for payment.

There is a $30.00 processing charge for non-sufficient funds or returned checks.

Notice to Patient:
No interest is imposed under this agreement. However, there will be a rebilling charge of $5 or 1.5% per month (whichever is greater) to the account should it become past due. If collection action is necessary, you agree to pay all court costs and collection fees, including reasonable attorney's fees, to the extent applicable by law.

Payment options:

1. Cash
2. Check
3. MasterCard
4. Visa
5. American Express
6. Discover
7. Credit Card authorization for recurring charges if:
    a. Treatment exceeds $200
    b. Down payment is made at first appointment

I, _____________________________, agree to these financial terms.

Signature____ Date________________________

Consent for Dental Treatment and Acknowledgement of Receipt of Information

Name: ____________________________ Date: ________________________

State Law requires us to obtain your consent for dental treatment. Please ask us about anything you do not understand. We are ready to answer any of your questions or explain anything you need. Any alternatives to the recommended treatment, including no treatment, have been explained to me.

I understand dentistry is not an exact science and complications may occur despite our best efforts. There are risks associated with any dental treatment. This includes the administration of any local or general anesthetic agent, analgesic agent(s) to produce conscious sedation, and/or pre-medication prior to dental care being rendered. Some of these risks/complications are, but are not limited to, the following:

Sensitivity to temperature (hot/cold)
Damage, fracture or possible loss of the tooth/teeth being treated as well as adjacent teeth and bone
Failure of wound to heal
Injuries to adjacent teeth and/or soft tissue
Parasthesia or numbness of: tongue, and/or mouth, and/or face
Fracture of mandible (upper jaw) or maxilla (lower jaw)
Opening between mouth and sinus or mouth and nose
Sloughing (unanticipated loss of hard and/or soft tissue)
Swallowing and/or aspiration of prosthesis and other objects
Trismus (jaw pain or difficulty opening mouth)
Additional surgery, hospitalization and/or further treatment may be required in the event of any complication(s)
Burns from chemical agents used in treatment or dental treatments
Loss of or damage to the ability to taste, speak, hear and/or see
Breakage or root(s) and retained root fragments

Damage to or possible loss of filings or other dental work
Change in bite
Incomplete removal of tooth
Loss of tooth/teeth or loss of bone
Dry socket
Injury to adjacent structures
Instrument breakage
Allergic reaction to drugs
Bacterial Endocarditis
Failure or treatment to accomplish its purpose
TMJ Dysfunction or worsening of TMJ condition
Injury from airborne particles or instruments
Infection
Bleeding
Tooth or fragment in maxillary sinus

State Law also requires that we specifically advise you, although rarely occurring, the dental treatment or anesthetic may result in: Paraplegia (paralysis of both legs); Quadriplegia (paralysis of both arms and legs); Loss or loss of function of an organ(s) or limb(s); Brain Damage; or Death.

After we reserve your appointment time with either the doctor or hygienist, we request a 48 hour notice if you need to change or cancel your appointment. Failure to give 48 hour notice will result in a minimum $80 missed appointment fee.

Patient Acknowledgment

I acknowledge that I have read, or that it has been read to me, and I understand the information contained on this consent form. I was given an adequate opportunity to ask any questions and all questions that were asked, were answered to my satisfaction. I hereby authorize and direct the dentist and/or associates, hygienists, assistants of their choice to perform the diagnostic, surgical or dental treatment. I have also received a copy of the Dental Materials Fact Sheet as required by law. This consent form will remain valid until revoked by me in writing.

______________________________ ______________
Signature of Patient or Guardian **Date**

Patient Acknowledgement of Receipt of Notice of Privacy Practices

The privacy of your health information is important to us. Please review this information carefully.

________________________________ ____________________

Print Patient's Name **Date**

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your health information. In addition, we are required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (04/14/03), and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

________________________________ ____________________

Patient Signature **Date**

Office Use Only

We attempted to obtain written acknowledgement or receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Patient Name: ______________________________

- ❑ Individual Refuses to Sign
- ❑ Communication Barriers – prohibited obtaining the acknowledgement
- ❑ Emergency Situation – prevented us from obtaining the acknowledgement
- ❑ Other – please explain: ____

________________________________ ____________________

Staff Signature **Date**