PATIENT REGISTRATION

PATIENT INFORMATION:

FIRST NAME: _____ ***LAST NAME:*** _____

MIDDLE INITIAL: _____ ***DATE OF BIRTH:*** _____

RESPONSIBLE PARTY INFORMATION

FIRST NAME: _____ ***LAST NAME:*** _____

MIDDLE INITIAL: _____ ***DATE OF BIRTH:*** _____

ADDRESS: _____

CITY: _____ ***STATE/ZIP:*** _____

HOME PHONE: _____ ***WORK PHONE:*** _____

CELL PHONE: _____ ***E-MAIL:*** _____

SOCIAL SECURITY # _____ ***DRIVERS LIC:*** _____

PLEASE FILL OUT THE NEXT 4 PAGES.

THANK YOU

Acknowledgement of Receipt
Notice of Privacy Practices

By signing below I acknowledge that I have received or reviewed the Notice of Privacy. I agree with the terms of th notice and understand my rights under this notice. **By signing below I consent for the use of my personal heal information for treatment, payment, operations and other uses as described in the privacy notice.** I also understand that I have the right not to sign this agreement.

Name:_____

Signature:_____

Relationship to Patient:_____

Date:_____

If we are unable to get your acknowledgement then our office will make a notation as to the reason why it is not obtained.

Reason why acknowledgment was not obtained:

_____

_____

_____

Staff Name:_____

Signature:_____

Date:_____

Comprehensive Dentistry for All Ages

At Comprehensive Dentistry we believe that you deserve the best care. That is why we always present you with the best dental solution possible to treat your personal situation. Each year we provide outstanding dental care to thousands of patients. Some have dental benefits but some do not. If you have dental benefits congratulations. You are very fortunate. Here are some important things you should know.....

Your dental benefits are based upon a contract made between your employer and an insurance company. If you have questions regarding your dental benefits please contact YOUR employer or insurance company direct. Dental benefits plans will never pay for the completion of your dental care. It is only meant to assist you.

We bill your insurance as a COURTESY. If insurances does not pay within 90 days, Comprehensive Dentistry reserves the right to request payment in full for services from you and let you collect the insurance funds that are due to you. This is rare but it is important that you recognize that the insurance you have is a legal contract between YOU and your insurance company. Our office is not and cannot be a part of that legal contract. Ultimately, YOU are responsible for all charges incurred in our office.

Comprehensive Dentistry does require payment in full for your portion at the time of service. We accept MasterCard, Visa, American Express, Discover, cash and checks. If you are in need of an extended finance option, we also work with Care Credit, who offers 6 month's interest free payment plan approved upon patients credit history. Just ask one of the staff for an application.

Broken Appointments: A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment we require at least 24 hour notice to avoid a $40 cancellation fee.

After Hours/Weekend Emergencies: In the event of an emergency after regular business hours a $55 emergency fee will be charged for established patients in addition to the necessary treatment fees. Patients who are not established in the practice will be charged $125 after hour emergency fee.

Confirmation Policy: Our office does give confirmation calls. We must have a verbal confirmation by 1:00 pm on the date prior to your appointment in order to hold your scheduled time. Failure to confirm with a member of our staff will result in appointment cancellation.

Initial Hygiene Appointment: For all new patients a Full Mouth Series of X-rays is taken to properly diagnosis any current decay. After the initial FMS, Bitewing X-rays are taken at your scheduled cleaning appointment depending on the frequency limitation set by your insurance.

Fluoride Policy: For all patients under the age of 18 we apply topical fluoride twice a year at each cleaning for preventive purposes. If your insurance company only pays for one application per year you will be responsible for the fee upon denial.

We Welcome you to our family and look forward to helping you get the healthy, beautiful smile you've always wanted. If there is anything we can do to make your visits more pleasant, please don't hesitate to ask one of our staff members.

Print name: _____

Signature: _____

Corby Gotcher,D.D.S.

Eaglesoft Medical History 06-14-2022

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
Are you on any blood thinners/aspirin? If Yes, List specific medication and your Cardiologist	Yes	No	If yes
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	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	Artificial Joint	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
Blood Transfusion	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	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						

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:_____

Financial Responsibility

I understand that I am financially responsible to Dr. Corby Gotcher for any charges not covered by health care benefits. It is my responsibility to notify Dr. Corby Gotcher of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by Dr. Corby Gotcher and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for products and services received.

In certain circumstances, insurance companies may send a check for services provided by Dr. Corby Gotcher directly to the patient. In such cases, the patient agrees to endorse and send such a check for the equivalent amount to Dr. Corby Gotcher within 10 days of having deposited the check from the insurance carrier.

I have requested medical services from Dr. Corby Gotcher on behalf of myself and/or my dependants, and understand by making this request that I become fully financially responsible for any and all charges incurred in the course of treatment authorized.

Name of person signing (print): _____

Relationship to Insured: _____

Signature of Insured: _____

Date: _____