Today's Date__________________

Patient's Name______________________________________ How do you wish to be addressed?__________________

Male______ Female_______

Date of Birth_________________ Soc. Sec. No._________________ Marital Status Married_____ Single_____ Widowed______ Divorced_____ Other_____ Minor_____

Address______________________________________ City________________ State___________ Zip__________

Phone_________________________ E-Mail_________________________ Best Time of Day to Reach you?_______

Alternate Phone___________________ Drivers License No.______________________

Whom may we thank for referring you to our office?____

Employer_______________________________ Position_________________ How long held?____________

Spouse/Parent Name____________________________

Date of Birth__________________Soc. Sec. No.____________________

Employer_______________________________ Position_________________ How long held?_____________

Who is Responsible for this account? _________________________ Relationship to Patient____________________

Dental Insurance 1st Coverage

Dental Insurance Subscriber Name_________________________ Employer______________________________

Employee Date of Birth________________________ Name of Insurance Company______________________________

Group or Policy #____________________________ Subcriber ID____

Dental Insurance 2nd Coverage

Dental Insurance Subscriber Name_________________________ Employer______________________________

Employee Date of Birth________________________ Name of Insurance Company______________________________

Group or Policy #____________________________ Subcriber ID____

Someone, not living with you, to notify in case of an emergency____

Release:

- I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.
- I authorize release of any information concerning my (or my child's) healthcare, advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits.
- I authorize release of any information concerning my (or my child's) health care, advice, and treatment to another dentist.
- I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.
- I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in party by my dental care payor.
- I attest to the accuracy of the information on this page.
- I understand where appropriate, credit bureau reports may be obtained.

Patient or Guardian's Signature____ Date__________________

REGISTRATION

PATIENT NAME ____
Last First Initial Date of Birth

CIRCLE THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION.

COMMENTS

1. Physician's Name ______________________
   Address ______________________
   ____
2. Are you under a physician's care? .... YES NO
   Since when ______________ Why ______________
3. When was your last complete physical exam? ______________
4. Are you taking any medication or substances? .... YES NO
   (If yes, please list medications on the back of this form.)
5. Do you routinely take health related substances? .... YES NO
6. Are you allergic to any medications or substances? .... YES NO
7. Do you have any other allergies? .... YES NO
8. Do you have any problems with penicillin, antibiotics, anesthetics or other medications? .... YES NO
9. Are you sensitive to any metals or latex? .... YES NO
10. Are you pregnant or suspect you may be? .... YES NO
11. Do you use any birth control medications? .... YES NO
12. Have you ever been treated for or been told you might have heart disease? .... YES NO
13. Do you have a pacemaker or an artificial heart valve implant? .... YES NO
14. Have you ever had rheumatic fever? .... YES NO
15. Are you aware of any heart murmurs? .... YES NO
16. Do you have high or low blood pressure? .... YES NO
17. Have you ever had a serious illness or major surgery? .... YES NO
    If so, explain ______________________
18. Have you ever had radiation treatment, chemo treatment for tumor, growth or other condition? .... YES NO
19. Do you have inflammatory diseases, such as arthritis or rheumatism? .... YES NO
20. Do you have any artificial joints / prosthesis? .... YES NO
21. Do you have any blood disorders, such as anemia, leukemia, etc.? .... YES NO
22. Have you ever bleed excessively after being cut or injured? .... YES NO
23. Do you have any stomach problems? .... YES NO
24. Do you have any kidney problems? .... YES NO
25. Do you have any liver problems? .... YES NO
26. Are you diabetic? .... YES NO
27. Do you have asthma? .... YES NO
28. Do you have epilepsy or seizure disorders? .... YES NO
29. Do you or have you had a venereal disease? .... YES NO
30. Have you tested HIV positive? .... YES NO
31. Do you have AIDS? .... YES NO
32. Have you had or do you test positive for hepatitis? .... YES NO
33. Do you or have you had T.B.? .... YES NO
34. Do you smoke, chew, use snuff or any other form of tobacco? .... YES NO
35. Do you consume alcoholic beverages? .... YES NO
36. Do you habitually use controlled substances? .... YES NO
37. Have you had psychiatric treatment? .... YES NO
38. Have you taken the prescription drugs fenfluramine, fenfluramine combined with phentermine (fen-phen), dexfenfluramine (redux), or other weight loss products? ... YES NO
39. Do you have any disease, condition, or problem not listed? .... YES NO
    If so, explain ______________________
40. Is there anything else we should know about your health that we have not covered in this form? ______________________
41. Would you like to speak to the Doctor privately about any problem? .... YES NO

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT / GUARDIAN'S SIGNATURE ______________________ DATE ______________

DENTIST'S SIGNATURE ______________________ DATE ______________

ANEST.

MED. ALERT

MEDICAL HISTORY

Patient Acknowledgement and Consent Form

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability act of 1996 (HIPAA) requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with one of HIPAA's requirements we are giving you a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices.

From time to time it may be necessary for us to make disclosures of your information in connection with our treatment. For example, we may make a referral to or consult with another dentist or other health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

Patient Acknowledgement

Please sign this form below to acknowledge that you have today either received or reviewed a copy of our notice of privacy practices.

I acknowledge that I have today received a copy of the Notice of Privacy Practices.

______________________________ ______________________________

Patient Signature Patient Name (please print)

I am also signing for my minor children: ____

(please print names)

Date: ____________________

Patient Consent

Please sign this form below to consent to our disclosures of your information that we deem necessary in order to provide you with proper treatment.

I consent to your disclosures of my information, which you deem are necessary in connection with my treatment. I understand that such disclosures may not be of the type listed above.

______________________________ ______________________________

Patient Signature Patient Name (please print)

I am also signing for my minor children: ____

I also give consent for my treatment to be discussed with the following individuals: (e.g. spouse, parent, adult child, care giver)

____

(please print names)

____

____

I also give my permission for information regarding ☐ appointments, ☐ insurance benefits, ☐ financial arrangements to be discussed with the above individuals.

Date: ____________________

For office use only

Patient refused to sign.

The following circumstances prohibited the patient from signing the Acknowledgement:

____

An emergency situation prevented the patient (parent/guardian) from signing the Acknowledgement.

______________________________ ______________________________

Office Personnel (signature) Office Personnel (print name)

Date: ____________________

Mark J.Connelly, DDS

St. Johns

Dental Care

Family, Cosmetic & Sedation Dentistry

BROKEN APPOINTMENT/CANCELLATION POLICY

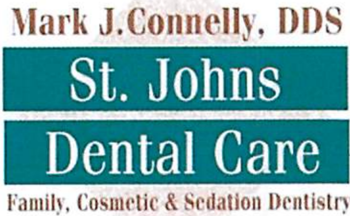
A missed appointment results in lost time which could be used for another patient waiting to receive treatment. If you fail to show for a scheduled appointment, all future appointments you may have scheduled will be cancelled. We also require 24 hour advance notice when cancelling an appointment that has been reserved for you. Depending on the nature of the cancellation, you may or may not be allowed to reschedule the appointment.

I have read and understand the policy.

______________________________ (Signature of patient or guardian)

______________________________ (Date)

______________________________ (Print Name)



Financial Policy

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered as part of your treatment. The following is a statement of our Financial Policy which we require you read and sign prior to any treatment. To our patients with Dental Insurance, you are most fortunate; please read the following regarding insurance reimbursement;

This office is happy to cooperate with families who are covered by dental insurance. We ask only that you read YOUR policy to be sure that you are fully aware of any limitations of benefits provided.

Full payment is due at time of service.
We accept cash, check, Visa, MasterCard, Discover and American Express. We also participate in Care Credit.

Regarding Insurance

We may accept assignment of insurance benefits. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your account in full within 45 days, any unpaid balance will be your responsibility and can be taken care of with cash, check, credit card, or for extended payments please contact our office. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and customary.

Minor Patients

The adult accompany a minor and parents (or guardian of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, major credit card, or payment by cash or check has been verified at the time of treatment.

Usual and Customary

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Thank you for reading and understanding our Financial Policy. Please let us know if you have questions or concerns.

Sign:______________________________ Date:______________________

Print:________________________________

Mark J.Connelly, DDS
St. Johns
Dental Care
Family, Cosmetic & Sedation Dentistry

SMILE EVALUATION

We would like to help you obtain the smile you've always wanted. Please take a few minutes to complete this short questionnaire. While using a mirror or looking at a photograph, please observe you teeth carefully.

1. Are you pleased with the color of your teeth?

____

2. Are you pleased with the shape of your teeth?

____

3. Are there spaces between your teeth that you don't like?

____

4. Do you have any concerns about bad breath?

____

5. Do you like the way your teeth fit together when you bite?

____

6. Are there old fillings or dental treatment that you aren't happy with?

____

7. If you could change anything about the appearance of your smile, what would that be?

____