Patient Registration

First Name: ______________________ Driver's License #______________________

Last Name: ______________________ Preferred Name: ______________________

Middle Initial: _______________ Marital Status: ________________________

Date of Birth: ___________________ Gender: ________

Address: ___________________________ _________________________________

City:_________________ State:__________________ Zip code:________________

Responsible Party's Name (if different from above): ___________________________

Email Address:____

Home Phone: _____________________ Cell Phone: _________________________

I give permission to Sunfish Dental to leave a detailed voicemail message for me at the numbers listed above: Initial _________________
Consent to receive text messages: Please initial ___________
Standard text message rates apply

Insurance Information:
Do you have dual insurance coverage? YES / NO (circle one)

Policy Holder's Name_________________________________

DOB of Policy Holder: ________________________________

Relationship to Patient: ______________________________

Employer: ____

Insurance Carrier____________________________________

Insurance Co. Phone Number__________________________

Insurance Co. Address (Claims)________________________

Group Number______________________Member ID or SSN: _________________________

Occupation: ____

How did you hear about us? __________________________

Patient/Parent or Guardian Signature________________________________ Date:___________

Time 3:31 PM | EagleSoft | Date 9/19/2020

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, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Question			
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?

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 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:___________

Office Policies

Thank you for choosing Sunfish Dental to be your dental provider! Dr. Tripp and her team are committed to providing the highest quality of care and best service possible. In order for our office to maintain efficiency for you, our patient, please take a moment to read through our office policies.

Dental Benefits

Please be prepared to show a valid photo ID and your current dental benefit card at each visit to our office. Dental benefits are a contract between you, your employer (if applicable) and the insurance company. As a courtesy, we will file your dental benefits claim for you and assist you with determining benefit information. However, if you have any additional questions about coverage, please contact your insurance company or human resources department. Please remember that dental benefits are not designed to cover 100% of the cost of all types of dental treatment. Generally the goal of most policies is to provide only basic care for specific dental services. The benefits that you receive have nothing to do with your needs or achieving a high quality, complete result. Many needed services may not be covered. Treatment recommended by our dental professionals is never based on what your dental benefits will pay, but on what our team feels is best for your overall dental health. At the time of treatment, the patient/guarantor is responsible for the estimated portion that your benefit plan does not cover (also called "copay"). Please remember that you are ultimately responsible for all expenses incurred. We request that you read your policy so that you are fully aware of coverage and any limitations of the benefits provided. In the event that a credit occurs on your account, this will remain there for future dental needs unless otherwise indicated.________(initial)

Financial Considerations

Financial arrangements are required before beginning any treatment that is not covered 100% by dental benefits. Payment, including your copay, is due on **the date of service** unless another arrangement has been made. The payment options available to you are:

- PAYMENT IN FULL: Payment is due at the time of the appointment.
- AUTO-PAY: For treatment exceeding $100.00, our office offers an auto-payment plan on your credit or debit card. 50% of the total cost of treatment is processed on the day that treatment begins, and a 25% monthly payment is processed until the account is paid in full.

THIRD PARTY FINANCING: CARE CREDIT or LENDING CLUB offers deferred interest for larger treatment plans. A minimum purchase is required, and subject to credit approval. For more information, visit: www.carecredit.com. ________(initial)

Referrals

If the treatment required to address your dental needs cannot be provided in our office due to a degree of specialization of treatment, a referral will be given to a provider who can provide the necessary care. It is the patient's responsibility to call and set up an appointment. Because the procedure will be carried out in another office, fees will vary from ours, and only the specialist's office can give you an accurate estimate of the cost.________(initial)

Scheduling

Due to the fact that we are reserving time on our schedule for your appointment, we ask that you contact us by phone with a minimum of two business days advanced notice for any appointments that you may need to cancel and/or change. We understand that conflicts arise; however, failing to attend your appointment or canceling without adequate notice more than 3 times will result in a $75 charge per appointment. This courtesy on your part will make it possible for us to offer your appointment time to another patient who needs to see the dentist or clinical team. ________(initial)

Delinquent Accounts
I agree to pay fees and expenses incurred by Sunfish Dental/Nicole Tripp, DDS, PLLC to collect on this account. After 90 days, all accounts that are not paid in full may be sent to a third party collection agency and are subject to interest at 1.5% monthly/18% annually. I agree to pay fees and expenses incurred by Sunfish Dental/Nicole Tripp, DDS, PLLC to collect on this account. It is agreed and understood that if this obligation should become delinquent that I, the patient or guarantor party, agree to pay the collection costs and costs associated with placing my obligation to a collection agency and/or attorney for litigation. ________(initial)

HIPAA Acknowledgement
I understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. Your personal health information will not be shared. I acknowledge that I have been provided with and understand this facility's Notice of Privacy Practices which provides a complete description of the uses and disclosures of my health information. I understand that I have the right to review this facility's Notice of Privacy Practices prior to signing this acknowledgement; this facility reserves the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy of any revised notice to the address I've provided if requested. ________(initial)

Agreement to Arbitration
By signing this agreement, the patient agrees with the office of Sunfish Dental/Nicole Tripp, DDS, PLLC that any dispute relating to dental care services rendered for any conditions, including any services rendered prior to the date this agreement was signed, and any dispute arising out of the diagnosis, treatment, or care of the patient, shall be resolved by binding arbitration. The patient understands that the result of this arbitration agreement is that claims, including malpractice claims he/she may have against the doctor, cannot be brought as the lawsuit in court before a judge or jury, and agrees that all such claims will be resolved as described in this section. I agree to pay fees and expenses incurred by Sunfish Dental/Nicole Tripp, DDS, PLLC to collect on this account. I understand that all balances 90 days and older are subject to interest at 1.5% monthly/18% annually. It is agreed and understood that if this obligation should become delinquent that I, the patient or guarantor party, agree to pay the collection costs and costs associated with placing my obligation to a collection agency and/or attorney for litigation. ________(initial)

Authorization and Release
I certify that I have read and understand the above information to the best of my knowledge. I authorize Sunfish Dental to release any information including the diagnosis and records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners where applicable. I authorize and request my insurance company to pay directly to the dental practice insurance benefits otherwise payable directly to me. I understand that my insurance carrier may pay less than the usual bill for the services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

____
Signature of Patient/Responsible Party

____ ______________________________________
Printed Name of Patient Date

Records Release

Patient Name: ______________________________ DOB ________________

Please include the NAMES and BIRTHDATES of any family members you wish to include in this records release:

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TRANSFER RECORDS TO Sunfish Dental. I authorize the following clinic to release my records, including all requested dental information, copies or photocopies of my dental record and radiographs, concerning treatment given to me at:

Dental Practice Name: ____

Phone Number: ____________________ Email: _________________________

Address: ____

Reason for Leaving: Moving
Insurance is out of network
Hours of Operation
Billing Problem
Other (Please specify):_____________________________________

TRANSFER RECORDS FROM Sunfish Dental. I am requesting my records be sent to:

[NEW OFFICE] Dentist/Clinic Name: _____________________________

Phone Number: _____________________ Email: _____________________________

Address: ____

____
Signature of Patient or Parent/Guardian

_________________________ __________________
Relationship to Patient Date