REGISTRATION

PATIENT INFORMATION

Last Name:		First Name:			Soc. Sec. #	
Address		City				
State	Zip	E-Mail				
Home Phone		Cell Phone				
Sex: ○Male ○Female ○Other	Age	Birth Date	○Single	○Married	○Divorced	○Child
Pronouns:			Occupation			
How did you hear of our office?			Employer			
In case of emergency who should be notified?			Phone			
How would you prefer to be contacted? ☐Text ☐E-mail ☐Phone Call						

If you have provided your insurance information prior to your appointment date the following sections are not required:

PRIMARY INSURANCE

Person Responsible for Account	Last Name		First Name
Relationship to Patient	Birth Date		Soc. Sec. #
Address (if different than patients)			Phone
City	State		Zip
Person Responsible Employed By			
Insurance Co.		Member ID	
Insurance Co. Address		Group Number	

SECONDARY INSURANCE

Person Responsible for Account	Last Name		First Name
Relationship to Patient	Birth Date		Soc. Sec. #
Address (if different than patients)			Phone
City	State		Zip
Person Responsible Employed By			
Insurance Co.		Member ID	
Insurance Co. Address		Group Number	

Health History

Dental Health

Patient Name_____

Reason for today's visit_____ Date of last dental care_____

Former dentist_____ Date of last dental x-rays_____

Check (✓) if you have had problems with any of the following:

☐ Bad Breath	☐ Grinding	☐ Jaw Pain
☐ Bleeding gums	☐ Loose teeth or broken fillings	☐ Sensitivity when biting
☐ Clicking or popping of jaw	☐ Periodontal treatment	☐ Sores or growths in your mouth
☐ Food collecting between teeth	☐ Sensativity to hot/cold	

How often do you floss?_____ How often do you brush?_____

Medical History

Physician's Name_____ Date of last visit_____

Have you had any serious illnesses or operations? If yes, describe_____

_____

Have you ever had a blood transfusion? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (✓) if you have or have had the following:

☐ Anemia	☐ Epilepsy	☐ Respiratory Disease
☐ Arthritis, Rheumatism	☐ Fainting	☐ Rheumatic Fever
☐ Artificial Heart Valves	☐ Glaucoma	☐ Scarlet Fever
☐ Artificial Joints	☐ Headaches	☐ Shortness of Breath
☐ Asthma	☐ Heart Murmur	☐ Skin Rash
☐ Back Problems	☐ Heart Problems	☐ Stroke
☐ Blood Disease	☐ Hemophilia	☐ Swelling of Feet or Ankles
☐ Cancer	☐ Hepatitis	☐ Thyroid Problems
☐ Chemical Dependency	☐ High Blood Preasure	☐ Tobacco Habit
☐ Chemotherapy	☐ HIV/AIDS	☐ Tonsillitis
☐ Circulatory Problems	☐ Kidney Disease	☐ Tuberculosis
☐ Cortisone Treatment	☐ Liver Disease	☐ Ulcer
☐ Cough, Persistent	☐ Mitral Valve Prolapse	☐ Venereal Disease
☐ Coughing up blood	☐ Pacemaker	
☐ Diabetes	☐ Radiation Treatment	

Medications

List medications you are currently taking:_____

_____

_____

Pharmacy Name: _____

Pharmacy Phone Number: _____

Allergies

☐ Aspirin	☐ Sulfa
☐ Barbiturates	☐ Latex
☐ Codeine	☐ None
☐ Local Anesthetic	Other_____
☐ Penicillin	_____

Signature

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of her staff responsible for any errors or omissions that may have been made in the completion of this form.

Patient Signature_____Date_____

Doctor Signature_____Date_____

RiverPlace DENTAL
Megan McInnis, DDS

Welcome Agreement

Welcome to our family of patients. We are delighted you have chosen the RiverPlace Dental team to provide you with your oral health care. We are committed to providing you with the highest quality dentistry and look forward to building a partnership to keep you and your smile as healthy as possible.

As a courtesy to you, we gladly process your insurance claims and provide you with an estimate of your co-pay for each visit. Each estimate is based off information given to us by your insurance carrier and is only an estimation. Ultimately you are responsible for any charges not paid by your plan. Please ready your insurance benefit booklet and understand all waiting periods, frequency limitations, exceptions, and exclusions. Know that we do everything possible to see that you receive the full benefits from your insurance company. If for some reason your insurance company. If for some reason your insurance company has not paid their portion with in 60 days from the start of your treatment, you are responsible for payment at that time.

We ask that if you must cancel a scheduled appointment that you kindly give 48 hours' notice. Dr. McInnis and the entire staff spend valuable preparation time arranging every detail for your visit. With respect to the staff that serves you and other patients who depend on us. We appreciate timely cancellation notifications and alerts if you are running late. If sufficient notice is not received there is a customary fee of $65.00 for a missed appointment.

We collect all out of pocket expense in full on the date of service. If you have a financial concern, we are happy to share with you our Care Credit payment plan options. There are no interest options as well as low interest extended plans designed to fit every budget.

We look forward to getting to know you better through the years to come, and happily welcome you to our practice.

I acknowledge that I understand the information listed above and consent to the welcome agreement.

Signature:_____Date:_____
(Signature of patient, parent, legal guardian, or responsible party)

Relationship to Patient:_____

RiverPlace DENTAL
Megan McInnis, DDS

HIPAA Privacy Form

The basics of HIPAA privacy and confidentiality refer to an individual's right to control access and disclosure of their protected health information (PHI). Under HIPAA, this means that information provided by the patient to the dental care provider and notes and observations about the patient's health will not be used for purposes other than treatment, payment, or dental operations.

If you want more information about our privacy practices or have questions or concerns, please let us know.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in the response to a request you made to amend or restrict the use of disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may submit a complaint to us using the contact information listed below this notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file with the department upon your request.

We support your right to privacy of your health information.

Patient Acknowledgement of HIPPA Disclosure and Consent for Necessary use of Personal Health Information

I consent to the use and disclosure of my personal health information by RiverPlace Dental during treatment, billing/payment and other various dental operations as outlined above.

Patient Signature_____Date_____