Benchmark Dental, PC

Patient Registration Form

Patient Information:

Patient First Name: _____ **M.I.** ____ **Last** _____

Address: _____
(No./Street) (City) (State) (Zip)

Age: ____ **DOB:** _____ **Home Phone:** ( )_____**Mobile Phone:** ( )_____

Sex: ☐ Male ☐Female **SSN:** _____**Email address:** _____

Marital Status: ☐ Married ☐Single ☐ Divorced ☐Widowed **Preferred Pharmacy:** _____

Billing Information:(if different from above)

Patient/Guardian First Name: _____ **M.I.** __ **Last** _____

Address: _____
(No. /Street) (City) (State) (Zip)

Home Phone: ( ) _____ **Business Phone:** ( )_____

Employer Information

Employer Name and Address: _____ **Work Number** ( ) _____

Insurance Information:

Primary Insurance Company: _____
Group No._____ **Policy No.**_____
Name of Insured: _____ **Relationship to Patient:** _____

Secondary Insurance Company_____
Group No._____ **Policy No.**_____
Name of Insured: _____ **Relationship to Patient:** _____

Check all that apply:

□ Complications from past dental treatment
□ History of local anesthetic reaction
□ Experiences dry mouth
□ Avoid brushing any part of your mouth
□ Whitened or bleached your teeth
□ Difficulty chewing
□ Currently or previously worn an occlusal guard
□ Diagnosed or treated for gum disease
□ Noticed an unpleasant taste or odor in mouth
□ Teeth become loose on their own (without injury)
□ Snores or wakes up frequently at night
□ Trouble getting numb
□ Had/have braces or orthodontic treatment
□ Sensitive to hot, cold, biting, or sweets
□ Food traps between any teeth
□ Popping and/or clicking or jaw joint
□ Clenching or grinding of teeth
□ Gums bleed when flossing or brushing
□ Bone loss around teeth
□ Experienced gum recession
□ Experienced oral burning sensations

Please list your previous dentist, name, and phone number:

_____

_____

Approximate date of most recent dental exam and/or dental x-rays:

_____

_____

Patient Medical Health History

Patient First Name: _____ M.I. _____ Last _____

Is your visit today due to a work accident? ☐Y ☐ N An injury? ☐Y ☐ N
Name of physician and date of last physical exam: _____

Have you recently been hospitalized? ☐Y ☐ N If yes, please explain: _____

Describe any current medical condition, impending surgery, or other treatment that may possibly affect your dental treatment:

_____

Are you currently taking any medications (prescription and non-prescription), including regular dosages of aspirin or blood thinners, i.e. Warfarin, Eliquis, Xarelto, Pradaxa? ☐Y ☐ N If yes, please list all medications and dosages below:_____

Any history of taking Fosamax, Boniva, Actonel, Reclast, Prolia or other medications containing bisphosphonates?

☐Y ☐ N If yes, please clarify with last dose or injection:_____

Women: Are you pregnant, or trying to get pregnant? **☐Y ☐ N** Due date: _____ Nursing? **☐Y ☐ N**

Please check any known drug allergies:

☐ Acrylic ☐ Amoxicillin ☐ Aspirin ☐ Codeine ☐ Epinephrine

☐ Hydrocodone ☐ Iodine ☐ Latex ☐ Local Anesthetics ☐ Sulfa Drugs

Please name any allergies not listed above _____

Do you have any artificial joints? ☐Y ☐ N If Yes, list which joint and date completed_____

Do you pre-medicate before dental appointments? ☐Y ☐ N If Yes, list PREMED _____
Preferred Pharmacy _____

Do any of the following medical conditions apply?

□ AIDS/HIV
□ Alcohol Abuse
□ Anemic/Bleeding Problems
□ Angina
□ Anxiety
□ Arthritis
□ Asthma
□ Cancer _____
□ Cardiac Pacemaker
□ Chest Pains
□ Convulsions
□ CPAP
□ Diabetes
□ Emphysema
□ Epilepsy/seizures
□ Fainting
□ Frequently Tired
□ Glaucoma
□ Heart Attack or Disease
□ Heart Murmur
□ Hepatitis A B C
□ High/Low Blood Pressure
□ Jaundice/Liver Disease
□ Kidney Disease
□ Marijuana Use
□ Mitral Valve Prolapse
□ Osteoporosis
□ Parkinson's
□ Radiation therapy
□ Rheumatic Fever
□ Sexually Transmitted Disease
□ Stomach Troubles/Ulcers
□ Swollen Legs or Ankles
□ Stroke
□ Thyroid Problems
□ Tobacco/Vape Use
□ Other_____
□ No known medical conditions

By signing, I acknowledge that I have reviewed ALL questions/alerts on this form and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes.

Patient/Guardian Signature _____ Date _____

Dentist's Signature _____ Date _____

REVIEWED BY STAFF_____

USE/RESTRICTION OF PATIENT INFORMATION

In general, the HIPAA privacy rules give individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

☐ Home Phone ☐ Mobile Phone ☐ Text ☐ Email ☐ Fax ☐Work Phone

If we reach your voicemail at any of the selected phone numbers, please check your preference:

☐ O.K. to leave message with detailed information ☐ Leave message with call-back number only ☐ No Message

I, _____authorize Benchmark Dental, PC to release any PHI to:

Name _____ Relationship _____ Phone number ( )_____

Name _____ Relationship _____ Phone number ( )_____

☐ Do Not Release my information to anyone

The Privacy Rule generally requires health providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

If you have any questions regarding our health information privacy practices, please contact us at (406) 256-2121 or by writing to: Benchmark Dental, PC, Privacy Officer, 2525 4th Ave N, Suite 1, Billings, Montana 59101

BILL PAY POLICY

As validated by my signature on the bottom of this form and my initials on the following lined items, I understand and accept each of the following policies:

1. ___ The portion of my balance due is expected to be paid at the time of service. Benchmark Dental, P. C. grants sixty (60) days for the insurance to pay; however, any balances pending insurance after sixty days or non-covered by insurance are the obligation of the responsible party.
2. ___ I understand that I am responsible for any charges not fully covered by my insurance company for any reason including, but not limited to- exclusions, exceptions, limitations, and "usual and customary" fees.
3. ___ Benchmark Dental, P. C. may check my dental insurance benefits as a courtesy and provide an estimated out of pocket for services rendered based on the information provided by my insurance company.
4. ___ Benchmark Dental, P. C. does not guarantee insurance benefits as my dental insurance contract is between me and my insurance company.
5. ___ Benchmark Dental, P. C. will submit claim forms directly to my insurance company if they have the correct insurance information and the insurance company will accept the claim from Benchmark Dental, P.C. Otherwise, it will be my responsibility to send claims to both my primary and (if applicable) my secondary insurance carrier.
6. ___ I will receive a monthly statement that will detail all charges, payments, and credits entered on my account during the month preceding the closing date of the statement. Payment is due within 30 days of the statement date.
7. ___ A compound finance charge equal to the maximum allowed by federal regulations will be levied against the unpaid balance of accounts that are ninety (90) days old or older.
8. ___ I understand that I will not be billed or held responsible for any charges if approved as a work-related incident.
9. **___I understand Benchmark Dental, P.C. requires all scheduled appointments to be confirmed by 3 p.m. the business day before my appointment. If I do not confirm my appointment or Benchmark Dental, P. C. is unable to reach me, I understand the time allocated for my appointment will be forfeited and given to another patient in need.**
10. **____ In fairness to other patients and to Benchmark Dental, P. C, I will provide at least a 24 hour notice to cancel my appointment. Otherwise, I could be charged a $50 deposit (per hour of scheduled time) to reschedule or dismissed from the practice as a patient.**
11. ___ I am able to request a copy of this policy to be retained by me.

Patient/Guardian Signature _____ Date _____