Patient Registration

Patient Name: _____ Today's Date: _____

Preferred Name (if other than legal name):_____

Address: _____
Street Address City State Zip Code

Gender: M / F Date of Birth_____

1st Parent or Guardian Name: _____ Preferred Phone #: _____

Parent or Guardian's Email: _____

2nd Parent or Guardian Name: _____ Preferred Phone #: _____

Parent or Guardian's Email: _____

Best method of contact (home# cell or email):_____

Emergency contact other than Guardian: _____ Relationship_____

Phone #: _____

Primary Dental Insurance Information	**Secondary Dental Insurance Information**
Ins. Co.:_____	**Ins. Co.:_____**
Ins. Co. Phone #:_____	**Ins. Co. Phone #:_____**
Name on Policy:_____	**Name on Policy:_____**
Employer:_____ Group #:_____	**Employer:_____ Group #:_____**
Subscriber:_____ **Please note Subscriber address if different from patient**	**Subscriber:_____** **Please note Subscriber address if different from patient**
SS# or ID#:_____Date of Birth:_____	**SS# or ID#:_____Date of Birth:_____**
Relationship to patient:_____	**Relationship to patient:_____**

CHILD HEALTH RECORD

Has your child been a patient in the hospital during the past 2 years?.....Yes / No

Reason:_____

Has your child taken any medicine, medication or drugs during the past year?.....Yes / No

List Medicine/Medication:_____

Is your child allergic to or made sick by Penicillin, Aspirin, Codeine, or any drugs or medications including local anesthetics?.....Yes / No

Has your child ever had any excessive bleeding requiring special treatment?.....Yes / No

Circle any of the following which your child has or has had in the past:

High Blood Pressure	Kidney Trouble	Hay Fever	Chronic Sinus	Thumb Sucking
Low Blood Pressure	Asthma	Cerebral Palsy	Allergies or Hives	Nail Biting
Pain in region of Ears	Arthritis	Measles	Bleeding Gums	Diabetes
Tuberculosis (TB)	Tonsilitis	Liver Disease	Yellow jaundice	Chemotherapy
Hepatitis A (infectious)	Hepatitis B (serum)	Cold sores	Chicken Pox	HIV / AIDS
Hemophilia	Venereal Disease	Fainting or dizzy spells	Nervousness	BloodTransfusion
Bruise easily	Tongue thrusting	Rheumatic Fever	Mouth Breathing	Anemia
Mastoid/ear infection	Congenital Heart lesions	Artificial Heart valve	Scarlet Fever	Mumps
Heart murmur	Heart surgery	Epilepsy or seizures	Sickle cell disease	

Is your child having pain or discomfort at this time?.....Yes / No
Does your child feel very nervous about having dental treatment?.....Yes / No
Has your child ever had a bad experience in any dental office?.....Yes / No
If there was a previous dental experience:
Was it satisfactory?.....Yes / No
Was a local anesthetic given?.....Yes / No
Were x-rays taken?.....Yes / No
Were home care instructions given?.....Yes / No
Were regular preventive visits made?.....Yes / No
Was there a history of dental decay?.....Yes / No
Were there any special problems?.....Yes / No

Please add anything you feel is important_____
_____
_____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I authorize the dentist to release any information including diagnosis and the records of any treatment or examination rendered to my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my dependents behalf. I hereby grant permission to the doctor to perform any necessary dental work for this child.

Parent or Guardian Signature: _____Date:_____

ACKNOWLEDGEMENT OF PRIVACY POLICY

Eric W. Ranta, D.D.S. David S. Russell, D.D.S.
Elizabeth C. Hansen, D.D.S.
3819 NE 45th Street
Seattle, WA 98105
(206) 524-6116

My signature confirms that I have been informed of my rights to privacy regarding my protected information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- **Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.**
- **Obtain payment from third-party payers for my health care services.**
- **Conduct normal health care operations such as quality assessment and improvement activities.**

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider had the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations, and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____ Date: _____

Signature: _____

Relationship to Patient: _____

Dependent family members also covered by this acknowledgement:

Additional Disclosure Authority
Any member of my immediate family _____ ☐Yes ☐No
Spouse only _____ ☐Yes ☐ No
Other-specify _____ ☐Yes ☐ No

- -

For office Use Only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

☐ The patient refused to sign
☐ Communication barriers
☐ Emergency situation
☐ Other

FINANCIAL POLICY

Thank you for choosing Drs. Ranta, Russell & Hansen.

We feel strongly that our patients deserve the best possible care we can provide. In an effort to provide and maintain that high quality, we would like to share some information about financing your dental care. Our hope is that by providing the following information we can prevent misunderstandings. We urge you to consult with us if you have any questions regarding our fees and/or services.

Patients Without Insurance

Patients without insurance are expected to pay their bill at time of service or when billed. After 30 days, bills are considered past due. A 5% courtesy adjustment will be given if you pay 100% of your treatment charges on the date of service with cash or with a check. A 3% courtesy adjustment will be given if you pay 100% of your treatment charges on the date of service with a Visa or Mastercard. Patients over 65 years of age will be extended a 5% courtesy adjustment (not to be combined with other discounts.)

Insurance Billing*

We will bill any private dental insurance company for which we receive **complete** billing information in a timely manner. Many patients are under the impression that if they have insurance coverage, it is the insurance company that owes the dentist for services rendered. The insurance contract is *between the patient and the insurance company*. Therefore, the patient is responsible for all account balances regardless of any insurance benefit. Many patients carry insurance for dental care but few have 100% coverage. Many insurance plans state that provided services will be covered for 50%, 80% or even 100%. We have found that many plans cover less depending upon insurance plan's "**usual and customary fees**." The benefits paid by your plan are largely determined by how much your employer/union paid for the plan. Insurance companies will pay a claim percentage based on **their** usual and customary fees, not our actual fees. Thus, your insurance coverage may be less than you expected. We encourage you to be familiar with your plan benefits.

*If we bill your insurance, bills may not be sent out until we receive a response from your insurance company.

We do not bill to Medicare or DSHS.

Third Party Billing

Our policy is NOT to bill a third party. Business, home and auto insurance are all considered third party. We consider patients that have third party relationships to be self pay patients. Please see the **Patients Without Insurance** section above.

Methods of Payment : We accept cash, check, VISA and MasterCard.

We reserve the right to charge $50.00 per hour for a missed appointment or late cancellation. Late cancellation is *less than 24` hours notice*.

I understand the terms and conditions as stated above and accept full financial responsibility for any treatment rendered.

_____

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3819 NE 45th Street
Seattle, WA 98105
(206) 524-6116
(206) 528-0406 fax
www.laurelhurstdentalgroup.com

Cancellation Policy

When an appointment is scheduled at our office we reserve that time especially for you. To help us better serve you and others, we require a **24 hour notice** if you need to reschedule or cancel your appointment. In the case of an emergency, please notify our office as soon as possible if you are unable to make your scheduled time.

We reserve the right to charge a broken appointment/late cancellation fee of $50.00 per hour changed or broken by patients with *less than 24 hours notice*.

We thank you for your cooperation.

Printed Name Signature Date