Patient Registration

Today's Date: _____

Patient Legal Name:_____ Name you prefer to be called:_____

Address:_____City:_____State:_____Zip:_____

Billing address (if different):_____City:_____State:_____Zip:_____

Home Phone:_____ Work Phone:_____ Cell:_____

Best method of contact (please circle one or more) : Home phone Work Phone Cell phone Email

Birthdate:_____SSN#_____ E-mail:_____

Employer / Occupation:_____

Spouse's Name:_____Spouse's Phone:_____

Emergency Contact Name:_____Phone:_____

Previous Dentist:_____

How did you hear about our office?_____

PLEASE COMPLETE ONE SECTION FOR EACH INSURANCE YOU WANT US TO BILL

Primary Insurance Information

Policy Holder's Name:_____ Date of Birth:_____

Policy Holder's Address:_____ Phone:_____

Policy Holder's Employer:_____ SSN#:_____

Name of Insurance Co.:_____ Ins. Phone:_____

Address of insurance Co.:_____ Group/Policy #:_____

ID#:_____ Patient's Relationship to Policy Holder:_____

Secondary Insurance Information

Policy Holder's Name:_____ Date of Birth:_____

Policy Holder's Address:_____ Phone:_____

Policy Holder's Employer:_____ SSN#:_____

Name of Insurance Co.:_____ Ins. Phone:_____

Address of insurance Co.:_____ Group/Policy #:_____

ID#:_____ Patient's Relationship to Policy Holder:_____

MEDICAL HISTORY

Are you in good Health?_____ Yes/No Are you presently under the care of a physician?_____ Yes / No

If yes, for what condition?_____

Physician name and phone #:_____

Have you ever been hospitalized, had a serious illness or had a major operation? _____ Yes / No

Please describe:_____

Please List any medications, over the counter or prescriptions that you are now taking:_____

_____

Have you ever had an allergic or unusual reaction to any of the following (Please circle):

Dental local anesthetics	Codeine or other narcotics	Aspirin, Acetaminophen or Ibuprofen
Latex	Penicillin	Sulfites or Sulfa

Any other medications, drugs or antibiotics: _____

Do you have significant anxiety regarding dental treatment?_____ Yes / No

Have you ever had any serious complications involving dental treatment?_____ Yes / No

Are you experiencing any dental pain at this time? _____Yes / No

Are your teeth sensitive? _____ Yes / No

Do you take medication before dental procedures? _____ Yes / No

Do you have temporomandibular disorder (TMD, TMJ)? _____ Yes / No

Do you clench or grind your teeth? _____ Yes / No

Do you ever wake up from sleep short of breath? _____ Yes / No

Do your ankles swell during the day? _____ Yes / No

Have you ever used any tobacco products? _____ Yes / No

Date of last dental cleaning:_____

FEMALE:

Are you pregnant?_____ Yes / No If yes, how many months? _____

Are you breastfeeding? _____ Yes / No Are you taking birth control pills? _____ Yes /No

_____

Circle any of the following which you have had or have at the present time:

HEART	**LUNGS**	**LIVER**
Congestive heart failure	Asthma	Liver disease
Congenital heart problems	Tuberculosis	Hepatitis A, B, C
Heart Surgery	Emphysema	Yellow jaundice
High/Low blood pressure		
Heart pacemaker	**HEAD**	**BLEEDING DISORDERS**
Heart murmur (pre-medicated Y/N?)	Chronic sinus problems	Hemophilia
Stroke	Allergies or hives	Bruise easily
Artificial heart valve	Hay fever	Sickle cell disease
Rheumatic fever	Cold sores/fever blisters	Anemia
		Blood transfusions
HORMONES	**INFECTIOUS DISEASE**	**CANCER**
Thyroid disease	H.I.V. or A.I.D.S.	**CHEMOTHERAPY**
Diabetes	Sexually transmitted diseases	**KIDNEY DISEASE**
	Other infectious disease	**X-RAY TREATMENT**

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 me or my child during the period of such dental care to third party payors and/or health practitioners or if underage my parent/guardian. 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 behalf or my dependents behalf.

SIGNATURE:_____ DATE:_____

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.

_____

Printed Name 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

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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