

PATIENT REGISTRATION

ID:

Chart ID:

First Name:

Last Name:

Middle Initial:

Patient Is: Policy Holder Responsible Party

Preferred Name:

Responsible Party (if someone other than the patient)

First Name:

Last Name:

Middle Initial:

Address:

Address 2:

City, State, Zip:

Pager:

Home Phone:

Work Phone:

Ext:

Cellular:

Birth Date:

Soc Sec:

Drivers Lic:

Responsible Party is also a Policy Holder for Patient

Primary Insurance Policy Holder

Secondary Insurance Policy Holder

Patient Information

Address:

Address 2:

City:

State / Zip:

Pager:

Home Phone:

Work Phone:

Ext:

Cellular:

Sex: Male Female

Marital Status: Married Single Divorced Separated Widowed

Birth Date:

Age:

Soc Sec:

Drivers Lic:

E-mail:

I would like to receive correspondences via e-mail.

Section 2

Section 3

Employment Status: Full Time Part Time Retired

Emergency Contact:

Student Status: Full Time Part Time

Previous Dentist:

Medicaid ID:

Pref. Dentist:

Referred by:

Employer ID:

Pref. Pharmacy:

Emergency Contact #:

Carrier ID:

Pref. Hyg:

Last Dental Exam:

Primary Insurance Information

Name of Insured:

Relationship to Insured: Self Spouse Child Other

Insured Soc. Sec:

Insured Birth Date:

Employer:

Ins. Company:

Address:

Address:

Address 2:

Address 2:

City, State, Zip:

City, State, Zip:

Rem. Benefits:

Rem. Deduct:

Secondary Insurance Information

Name of Insured:

Relationship to Insured: Self Spouse Child Other

Insured Soc. Sec:

Insured Birth Date:

Employer:

Ins. Company:

Address:

Address:

Address 2:

Address 2:

City, State, Zip:

City, State, Zip:

Rem. Benefits:

Rem. Deduct:

Eaglesoft Medical History(Copy)

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, c

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?

AIDS/HIV Positive	<input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine	<input type="radio"/> Yes <input type="radio"/> No	Hemophilia	<input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments	<input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease	<input type="radio"/> Yes <input type="radio"/> No	Diabetes	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis A	<input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss	<input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis	<input type="radio"/> Yes <input type="radio"/> No	Drug Addiction	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C	<input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis	<input type="radio"/> Yes <input type="radio"/> No
Anemia	<input type="radio"/> Yes <input type="radio"/> No	Easily Winded	<input type="radio"/> Yes <input type="radio"/> No	Herpes	<input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever	<input type="radio"/> Yes <input type="radio"/> No
Angina	<input type="radio"/> Yes <input type="radio"/> No	Emphysema	<input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Rheumatism	<input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout	<input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures	<input type="radio"/> Yes <input type="radio"/> No	High Cholesterol	<input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever	<input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve	<input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding	<input type="radio"/> Yes <input type="radio"/> No	Hives or Rash	<input type="radio"/> Yes <input type="radio"/> No	Shingles	<input type="radio"/> Yes <input type="radio"/> No
Artificial Joint	<input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst	<input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia	<input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease	<input type="radio"/> Yes <input type="radio"/> No
Asthma	<input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness	<input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat	<input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble	<input type="radio"/> Yes <input type="radio"/> No
Blood Disease	<input type="radio"/> Yes <input type="radio"/> No	Frequent Cough	<input type="radio"/> Yes <input type="radio"/> No	Kidney Problems	<input type="radio"/> Yes <input type="radio"/> No	Spina Bifida	<input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion	<input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea	<input type="radio"/> Yes <input type="radio"/> No	Leukemia	<input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease	<input type="radio"/> Yes <input type="radio"/> No
Breathing Problems	<input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches	<input type="radio"/> Yes <input type="radio"/> No	Liver Disease	<input type="radio"/> Yes <input type="radio"/> No	Stroke	<input type="radio"/> Yes <input type="radio"/> No
Bruise Easily	<input type="radio"/> Yes <input type="radio"/> No	Genital Herpes	<input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs	<input type="radio"/> Yes <input type="radio"/> No
Cancer	<input type="radio"/> Yes <input type="radio"/> No	Glaucoma	<input type="radio"/> Yes <input type="radio"/> No	Lung Disease	<input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No
Chemotherapy	<input type="radio"/> Yes <input type="radio"/> No	Hay Fever	<input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse	<input type="radio"/> Yes <input type="radio"/> No	Tonsillitis	<input type="radio"/> Yes <input type="radio"/> No
Chest Pains	<input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure	<input type="radio"/> Yes <input type="radio"/> No	Osteoporosis	<input type="radio"/> Yes <input type="radio"/> No	Tuberculosis	<input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blisters	<input type="radio"/> Yes <input type="radio"/> No	Heart Murmur	<input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints	<input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths	<input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder	<input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker	<input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease	<input type="radio"/> Yes <input type="radio"/> No	Ulcers	<input type="radio"/> Yes <input type="radio"/> No
Convulsions	<input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease	<input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care	<input type="radio"/> Yes <input type="radio"/> No	Venereal Disease	<input type="radio"/> Yes <input type="radio"/> No
Yellow Jaundice	<input type="radio"/> Yes <input type="radio"/> No						

Have you ever had any serious illness not listed above? Yes No If yes _____

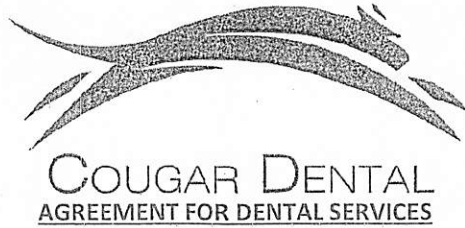
Comments:

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: _____



At Cougar Dental, our first priority is to you as our patient. We are glad you have chosen Cougar Dental for your dental needs. We look forward to providing you with quality service and the best experience possible. To make this happen, we rely on your representation that you will pay our office for the service we provide. In hiring our office to provide you with dental services, you agree to the following terms:

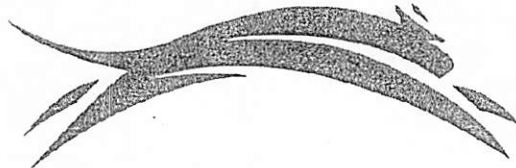
1. _____ **Courtesy Insurance Claim.** Dental insurance is a contract between a patient/guardian and the insurance company and in no way absolves the patient/guardian of full responsibility for the charges incurred. Estimates of insurance payment made by this office are considered a guideline only. We can make no guarantee of the insurance payment(s) estimated. We are pleased to process insurance forms, help maximize your insurance benefits and are glad to help answer any questions you may have about your treatment estimates. If no payment has been received after 60 days, your claim will be closed.
2. _____ **You are responsible to pay your entire bill** Insurance benefits are determined by your insurance provider; not your dentist. Your insurance policy is a contract between you and your insurance company. Any deductible or estimated co-payment amount will be due at the time of treatment. Proof of insurance is not a guarantee of payment; insurance typically will not pay for all of your costs.
3. _____ **Payment is due at the time of service are rendered.** For your convenience we accept Cash, Visa, Mastercard, American Express, Discover and personal checks. (Prior to commencing treatment, payment plans and financing arrangements can be made for most dental treatments, by way of a separate Payment Plan contract. For your convenience outside financing is also available, through Care Credit. A late fee of \$10/month will be assessed to all past due accounts.
4. _____ **Returned Check Fee.** Cougar Dental charges a return check fee of \$25.00 for any check that is dishonored for any reason.
5. _____ **Collection.** By signing below I agree to pay all amounts owed within 60 days of when such amounts are incurred. I understand that it is my responsibility to provide correct/updated insurance information and that this office will bill my insurance as a courtesy to me. However, regardless of insurance coverage, I agree that it is and shall remain my responsibility to pay all amounts owing as set forth herein. I agree that interest will accrue on all past due amounts at the rate of 18% per annum (1.5% per month) until paid in full. In the event any amounts are referred to a third party debt collections agency. I will also be responsible for a collection fee of up to 33% of the principal amounts owing as allowed Utah Code Annotated, Title 12 Chapter 1 Section 11. The terms of this paragraph shall apply to all amounts incurred by me or by any individual for whom I have legal responsibility whether such amounts are incurred today or after today.
6. _____ **48-hour Cancellation Policy:** Appointments are reserve exclusively for you. As a health benefit to you, we may offer to move your appointment to an earlier time if openings arise. Cougar Dental reserves the right to charge a \$50.00 fee for any appointment that is missed/ late or cancelled without 48-hours advance notice. If you are over 20 minutes late for your appointment we will automatically cancel your appointment time and the 48-hour late cancellation policy will apply.

I have read, understand and agree to all of the terms in the Agreement for Dental Services.

Responsible Party's Name (print)

Signature

Date



COUGAR DENTAL

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practice, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice at any time by contacting:

Cougar Dental
Telephone: 801-373-7700
FAX: 801-370-0762
Email: cougar.dental@yahoo.com
Address: 835 North 700 east
Provo, UT 84606

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the contact information listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we decline to treat you or to continue treating you if you revoke this consent.

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations

Signature: _____ Date: _____