Alpine Dental & Wellness

PATIENT REGISTRATION and AUTHORIZATION for MINORS

Alpine Dental & Wellness

ABOUT YOU

Name: _____ Preferred Name: _____

Gender: M F Birthdate: / / AGE: Grade in School: _____

Home Address: _____

Home Phone Number: _____ Who schedules your appointments: _____

Emergency Contact and Phone Number : (not living at same address) _____

PARENT INFORMATION

Mother's Name: _____ Mother's Birthdate: / / Age: _____

Mother's Social Security Number: _____ Mother's Email: _____

Mother's Mobile Phone Number: _____ Other Number: _____

Mother's Employer: _____ Employer Phone Number: _____

Father's Name: _____ Father's Birthdate: / / Age: _____

Father's Social Security Number: _____ Father's Email: _____

Father's Mobile Phone Number: _____ Other Number: _____

Father's Employer: _____ Employer Phone Number: _____

ABOUT YOUR COVERAGE

Primary Insurance Company: _____

Subscriber Name: _____ Date of Birth: / /

Identification Number: _____ Social Security Number: _____

Group Number: _____ Union: No Yes: Local Number: _____

Secondary Insurance Company: _____

Subscriber Name: _____ Date of Birth: / /

Identification Number: _____ Social Security Number: _____

Group Number: _____ Union: No Yes: Local Number: _____

When was your last dental visit: _____ What brings you in today?: _____

How did you hear about us? _____

Your appointment time is reserved just for you. We reserve the right to charge a minimum of $75 per hour appointment in order to cover expenses occurred during the allotted time for your appointment should you not show up or your appointment is cancelled with less than 24 hours' notice. We collect a deposit/down payment, for all major services and long appointments (2 or more hours). This deposit may become forfeit should you fail your appointment.

INITIAL: X _____

HEALTH HISTORY

Are you under the care of a Physician: NO YES Name and Phone Number of Doctor: _____

Have you been hospitalized in the past 12 months: NO YES Explain: _____

Do you smoke or use tobacco in any form: NO YES Please list any prescription, over the counter drugs or herbal supplements you are currently taking/using: _____

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Have you have or ever had the following:

☐ YES ☐ NO	MVP	☐ YES ☐ NO	Heart Attach/Stroke	☐ YES ☐ NO	Radiation Treatment
☐ YES ☐ NO	Abnormal Bleeding	☐ YES ☐ NO	Heart Murmur, Angina	☐ YES ☐ NO	Rheumatic/Scarlet Fever
☐ YES ☐ NO	AIDS/HIV/ARC	☐ YES ☐ NO	Pacemaker/Defibrillator	☐ YES ☐ NO	Shingles
☐ YES ☐ NO	Arthritis/Rheumatism	☐ YES ☐ NO	Hemophilia	☐ YES ☐ NO	Sickle Cell Disease
☐ YES ☐ NO	Artificial Bones/Joints/Heart Valves	☐ YES ☐ NO	Hepatitis	☐ YES ☐ NO	Sinus Problems
☐ YES ☐ NO	Asthma	☐ YES ☐ NO	High/Low Blood Pressure	☐ YES ☐ NO	Thyroid Problems
☐ YES ☐ NO	Blood Transfusion	☐ YES ☐ NO	Leukemia	☐ YES ☐ NO	Tuberculosis
☐ YES ☐ NO	Cancer/Chemotherapy	☐ YES ☐ NO	Liver Disease	☐ YES ☐ NO	Tumors/Growth
☐ YES ☐ NO	Diabetes	☐ YES ☐ NO	Nervous Disorder, Epilepsy/Seizures	☐ YES ☐ NO	Ulcers/Colitis
☐ YES ☐ NO	Heart Disease/Heart Failure	☐ YES ☐ NO	Psychiatric Problems	☐ YES ☐ NO	Venereal Disease

OTHER: _____

Are you taking or have taken the following in the past 6 months:

☐ YES ☐ NO	Bisphosphonates or medicine for osteoporosis Or Cancer (Fosamax, Aredia, Zometa, etc.)	☐ YES ☐ NO	Steroids (Cortisone, Prednisone, Hydrocortisone)
☐ YES ☐ NO	Blood Thinners (Coumadin, Plavix, Aspirin)	☐ YES ☐ NO	Tranquilizers (Valium, Xanax, Klonopin, Risperdal, Haldol, etc.)

Have you had and ALLERGY or ADVERSE REACTION to any of the following:

☐ YES ☐ NO	Aspirin, Acetaminophen, Ibuprofen	☐ YES ☐ NO	Latex	☐ YES ☐ NO	Penicillin or other Antibiotics
☐ YES ☐ NO	Barbiturates, Sedatives	☐ YES ☐ NO	Local Anesthetics	☐ YES ☐ NO	Sulfa Drugs
☐ YES ☐ NO	Codeine, Demerol, or other Narcotics	☐ YES ☐ NO	Metal/Plastic	☐ YES ☐ NO	Other _____

I, the undersigned, do hereby acknowledge that I have read, answered to the best of my knowledge, and understood all statements on this document:

- We keep a record of the dental/health care services we provide you. You may ask to see and receive a copy of that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our office.
- I acknowledge availability of a copy of the office Notice of Privacy Practices should I wish to receive one.
- I understand that this information will be held in the strictest of confidence and if I ever have any changes in my health or medicines, it is my responsibility to inform the office and doctor at my next appointment.
- This office offers Nitrous Oxide (Laughing gas) to our patients for $70. Most insurance does NOT pay for this option and payment is due at time of use.
- This office accepts most insurances but this does NOT guarantee payment of coverage from insurance companies. Payment is due at or before time of service. To this end, I authorize the release of any medical/dental information requested by my insurance company. I authorize payment of benefits directly to my Providers office.
- Finance charges may be charged to balances over 60 days at the rate of 9% per annum. If my account becomes past due, I/we agree to pay all attorney fees, court costs, filing fees and process service fees which may be assessed by any collection agency or law firm retained to pursue the matter and for the venue and jurisdiction to be in Snohomish County.
- You and /or your assignees are hereby authorized to contact me by any telephone numbers, pagers, cell phones, emails and addresses provided by me, or otherwise obtained by you, using an automatic telephone dialing system and to leave prerecorded messages on theses devises
- I hereby authorize my Providers office to administer such medication and perform such diagnostic and therapeutic procedures as may be necessary for proper medical/dental care for the Minor named above whether I am present or not when the treatment is rendered.
- Payment is due at time of your visit.
- I am responsible to give all contact information for all responsible parties for proper billing for each visit, should any changes take place.

Signature of Patient or Guardian _____ Printed name of Guardian _____ Date _____