Alpine Dental & Wellness

PATIENT REGISTRATION and AUTHORIZATION for ADULTS

Alpine Dental & Wellness

ABOUT YOU

Name: _____ Preferred Name: _____

Gender: M F Status: Single Married Child Other Birthdate: / / AGE: _____

Social Security Number: _____ Email: _____

Home Address: _____

Home Phone Number: _____ Mobile Phone Number: _____

Employer: _____ Employer Phone Number: _____

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

ABOUT YOUR SPOUSE

Name: _____ Preferred Name: _____

Gender: M F Birthdate: / / AGE: Social Security Number: _____

Mobile Phone Number: _____ Other Number: _____

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 Blood Thinners (Coumadin, Plavix, Aspirin)

YES NO Steroids (Cortisone, Prednisone, Hydrocortisone)

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.
- Payment is due at time of your visit.

Signature of Patient or Guardian _____ Date