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

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

Cell phone

EMAIL CONFIRMATION!

Recall frequency

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:

Skyway Dental Clinic

MEDICAL HISTORY 4-17-15

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, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	○ Yes ○ No	If yes	
Have you been hospitalized or had an operation?	○ Yes ○ No	If yes	
Have you ever been told that you need antibiotics prior to a dental appointment?	○ Yes ○ No		
Are you taking any medications, pills, or drugs?	○ Yes ○ No	If yes	
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes	
Do you use tobacco?	○ Yes ○ No		

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

Do you use controlled substances?	○ Yes ○ No	If yes	
Other?	☐	If yes	

Do you have, or have you had, any of the following?

AIDS/HIV Positive	○ Yes ○ No	Radiation Treatments	○ Yes ○ No	Alzheimer's Disease	○ Yes ○ No	Diabetes	○ Yes ○ No
Hepatitis A	○ Yes ○ No	Recent Weight Loss	○ Yes ○ No	Drug Addiction	○ Yes ○ No	Hepatitis B or C	○ Yes ○ No
Anemia	○ Yes ○ No	Rheumatic Fever	○ Yes ○ No	Emphysema	○ Yes ○ No	High Blood Pressure	○ Yes ○ No
Arthritis/Gout	○ Yes ○ No	Epilepsy or Seizures	○ Yes ○ No	High Cholesterol	○ Yes ○ No	Artificial Heart Valve	○ Yes ○ No
Excessive Bleeding	○ Yes ○ No	Hives or Rash	○ Yes ○ No	Shingles	○ Yes ○ No	Artificial Joint	○ Yes ○ No
Excessive Thirst	○ Yes ○ No	Hypoglycemia	○ Yes ○ No	Asthma	○ Yes ○ No	Fainting Spells/Dizziness	○ Yes ○ No
Irregular Heartbeat	○ Yes ○ No	Sinus Trouble	○ Yes ○ No	Blood Disease	○ Yes ○ No	Frequent Cough	○ Yes ○ No
Kidney Problems	○ Yes ○ No	Blood Transfusion	○ Yes ○ No	Stomach/Intestinal Disease	○ Yes ○ No	Breathing Problems	○ Yes ○ No
Frequent Headaches	○ Yes ○ No	Liver Disease	○ Yes ○ No	Stroke	○ Yes ○ No	Bruise Easily	○ Yes ○ No
Low Blood Pressure	○ Yes ○ No	Cancer	○ Yes ○ No	Glaucoma	○ Yes ○ No	Lung Disease	○ Yes ○ No
Thyroid Disease	○ Yes ○ No	Chemotherapy	○ Yes ○ No	Hay Fever	○ Yes ○ No	Mitral Valve Prolapse	○ Yes ○ No
Tonsillitis	○ Yes ○ No	Chest Pains	○ Yes ○ No	Heart Attack/Failure	○ Yes ○ No	Osteoporosis	○ Yes ○ No
Tuberculosis	○ Yes ○ No	Cold Sores/Fever Blisters	○ Yes ○ No	Heart Murmur	○ Yes ○ No	Pain in Jaw Joints	○ Yes ○ No
Tumors or Growths	○ Yes ○ No	Congenital Heart Disorder	○ Yes ○ No	Pacemaker/Defibrillator	○ Yes ○ No	Ulcers	○ Yes ○ No
Heart Trouble/Disease	○ Yes ○ No	Psychiatric Care	○ Yes ○ No	Yellow Jaundice	○ Yes ○ 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:_____

Skyway Dental Clinic
250 2nd Avenue South Suite 250
Minneapolis, MN 55401
(612) 338-4122

HIPAA Consent Form

Section A: Patient Giving Consent

Patient Name _____ Date _____

Section B: Patient- Please read the following statements carefully.

1. *Purpose of Consent:*
    a. By signing this form, you will consent to our disclosure of your protected health information to carry out treatment, payment activities, and healthcare operation.
2. *Notice of Privacy Practices:*
    a. You have the right to read our Notice of Privacy Practices before you decide 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 other important matters about your protected health information. You can read or receive a copy of our Notice at the front desk. We encourage you to read it carefully and completely before signing this Consent.
    b. We reserve the right to change our privacy practices as described in our Notices of Privacy Practices. If we change our privacy, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.
3. *Right to Revoke:*
    a. You will have the right to revoke this Consent at any time by giving us written notice of revocation (see back of page) submitted to the address above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received revocation and that we may decline to treat you or to continue treating if you revoke this Consent.

Section C: Personal Information Consent

1. I have the option to allow individuals other than myself to make appointments on my behalf.
2. I have the option to allow individuals to call for account information on my behalf.

Section D: Signature

I have had full opportunity to read and consider 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 healthcare operations.

_____ _____
Signature of Patient or Legal Guardian* Date

_____ _____
Printed Name of Patient or Legal Guardian* Date

**If Consent is signed by someone other than the patient, complete the following:*

_____ _____
Name of Patient's Representative Relationship to Patient

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU HAVE SIGNED IT.

Revocation of Consent

- I have received my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.
- I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

_____ _____

Signature of Patient or Representative Date

_____

Printed Name of Patient or Representative

OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign.
- ☐ Communication barriers prohibited obtaining the acknowledgement.
- ☐ An emergency situation prevented us from obtaining consent.
  - o Emergency _____
- ☐ Other _____

Skyway Dental Clinic

P| (612) 338-4122
F | (612) 338-1713
E | drfred@skywaydental.com

250 2nd Avenue S. Suite 250
Minneapolis, MN 55401

CONSENT TO RECORDS TRANSFER

I hereby authorize Fredrick R. Schilling, DDS and his staff to request the transfer of records from any previous dentist or physician, which he may deem pertinent and useful in my future treatment. I further consent to the release of my records from Dr. Schilling's office to any other practitioner, specialist, or other referred dentist, physician, therapist, or insurance carrier that may have reasonable need for such records in the future. I understand that Dr. Schilling will endeavor to maintain confidentiality of all unrelated personal and medical or dental information, when possible. If I have any questions concerning this consent, I understand that Dr. Schilling or his staff are available to answer them.

_____
Date

_____
Signature of Patient, Parent, or Guardian

_____
Patient Name

SKYWAY DENTAL CLINIC'S FINANCIAL POLICY

Patients with Insurance

- As a courtesy to our patients, we will submit completed treatment to your insurance carrier. It is imperative, however, that you are aware of the frequencies and limitations of your insurance policy, so there are no surprises after your visit with us. *Your social security number is required to be on file.*
- **The estimated out of pocket expense is due in full the day of service.**
- If there is a balance due after the insurance company has paid their portion, we will send you a statement to settle the account. In the case of overpayment to our office, we will promptly send you a refund check.

Patients without Insurance

- Our fees are the same regardless of whether you are insured or not.
- **All expenses are due the day of service.** Payment is accepted in the following forms:
  - We accept all major credit cards: VISA, MasterCard, Discover, and American Express.
  - A courtesy of 5% is offered if paid in full with cash or check.
  - We offer a 5% senior discount for patients 55 years and older.
  - In the unlikely event of a returned check (NSF), we will add a $25 Returned Check Fee to your account.
  - Financing is only available through *Care Credit* (upon credit approval). You may apply in office or in the privacy of your home. *Your social security number is required to be on file.* In-house financing is not available.

Broken Appointments

- **We require *at least 24 hours notice* if you need to cancel or reschedule an appointment.**
  - Appointments MUST be canceled or rescheduled by calling the office and speaking to a staff member.
  - Noncompliance will incur ***up to a $70 fee*** for each broken appointment.
  - We reserve the right to change your patient status to "Same Day" appointments.
  - We reserve the right to dismiss patients if appointments are broken without proper notice.

Outstanding Balances

- We reserve the right to deny scheduling appointments if your account is delinquent.
- A monthly billing charge of $1.00 will be added to accounts 30 days past due.
- A monthly finance charge of 1.5% (18% annually) will be added to accounts 60 days past due.
- Once your account reaches 90 days past due, we reserve the right to begin the collections process.

Emergency Appointments

- **If you have dental insurance, the estimated out of pocket expense is due in full the day of service.**
- **If you are uninsured, all expenses are due in full the day of service.**
- All other financial policies apply.

BREACH OF SIGNED FINANCIAL POLICY WILL RESULT IN DISMISSAL FROM PRACTICE.

I understand any treatment completed will be submitted to insurance, if applicable, and any balance remaining is my responsibility as the patient. In the unlikely event I default on this agreement and a collection agency becomes involved, I understand I am responsible for any collection costs incurred in addition to my outstanding balance.

_____ _____

Signature of Patient, Guardian, or Responsible Party Date

_____

Printed Name of Patient

EPWORTH SCALE

Patient Name _____ Today's Date _____

Please fill out the following information to the best of your knowledge:

DOB: ____/____/____ Age: _____
Height: _____ft _____ in Weight: _____ lbs
Neck Size: _____ inches Waist Size: _____ inches

Current Medications

Medication	Dose

Please answer how likely you are to doze or fall asleep in the following situations. Use the scale provided.
0 – Would never doze 1 – Slight chance of dozing 2 – Moderate chance of dozing 3 – High chance of dozing

Situation	Chance of Dozing 0 1 2 3
Sitting and reading	☐ ☐ ☐ ☐
Watching television	☐ ☐ ☐ ☐
Sitting inactive in a movie or meeting	☐ ☐ ☐ ☐
Riding in a car as a passenger for more than an hour, without a break	☐ ☐ ☐ ☐
Lying down to rest in the afternoon	☐ ☐ ☐ ☐
Sitting and talking to someone	☐ ☐ ☐ ☐
Sitting quietly after lunch without alcohol	☐ ☐ ☐ ☐
In a car, while stopped for a few minutes in traffic	☐ ☐ ☐ ☐
TOTAL SCORE	

Chief Complaint
Please check all that apply.

	Loud snoring		Daytime tiredness
	Witnessed Apnea		Depression
	Obesity		High blood pressure
	Waking up coughing		Morning headaches
	Never feel rested		Weight gain
	Decreased concentration		Frequent bathroom use at night

OFFICE USE ONLY

Enlarged Tonsils?
YES / NO **If yes, what size?*_____

Mallampati Classification
Class 1: ___
Class 2: ___
Class 3: ___
Class 4: ___