# WELCOME!

PATIENT REGISTRATION FORM

The following confidential information is for our records only

Welcome to Dr. Heidrich's office. We sincerely appreciate you choosing our office for your health care needs. Please be assured that we will work hard to continually earn the trust that you have placed in us. In order for us to serve you better, please take several minutes to complete this information form as thoroughly as possible.

## Tell Us about Yourself

Dr. /Mr. / Mrs. /Miss. /Ms. (please circle) Male or Female (please circle)

(First, middle initial, last) Name_____ Date of Birth____/____/____

Home Address_____City_____State____Zip_____

Home # (_____) _____ Cell # (_____) _____

Social Security# _____-_____-_____ E-mail Address_____

Spouse/Parent/Guardian Name _____Cell/Work # (_____) _____

## Employment

Full time/ Part time/ Retired/Student

Place of Employment/School _____Work# (_____) _____

## Dental Insurance

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone # (_____) _____

Group # (Plan, Local, or Policy #) _____

Policy Owner's Name _____

Relationship to Patient _____

Policy Owner's Birth date _____/_____/_____

Social Security #/or Subscriber ID # _____

Policy Owner's Employer _____

**Referral:** Who may we thank for referring you to our office? _____

AUTHORIZATION for TREATMENT: I request and authorize Dr. Heidrich and his staff to examine, clean and provide me with comprehensive dental treatment; including fillings, crowns, extractions, xrays, root canal therapy and nitrous oxide, if required. I further authorize the taking of dental xrays to help diagnose or treat my dental condition.

Patient (Guardian's) Signature _____

PAUL D. HEIDRICH, III, DMD

# 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, 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 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 use tobacco? | ○ Yes ○ No | |
| Do you have to take antibiotics before dental procedures | ○ 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 |
| ☐ Latex | ☐ Sulfa Drugs | ☐ Local Anesthetics | ☐ Metal |

| | | |
|---|---|---|
| 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 | Cortisone Medicine | ○ Yes ○ No | Hemophilia | ○ Yes ○ No | Radiation Treatments | ○ Yes ○ No |
| Alzheimer's Disease | ○ Yes ○ No | Diabetes | ○ Yes ○ No | Hepatitis A | ○ Yes ○ No | Recent Weight Loss | ○ Yes ○ No |
| Anaphylaxis | ○ Yes ○ No | Drug Addiction | ○ Yes ○ No | Hepatitis B or C | ○ Yes ○ No | Renal Dialysis | ○ Yes ○ No |
| Anemia | ○ Yes ○ No | Easily Winded | ○ Yes ○ No | Herpes | ○ Yes ○ No | Rheumatic Fever | ○ Yes ○ No |
| Angina | ○ Yes ○ No | Emphysema | ○ Yes ○ No | High Blood Pressure | ○ Yes ○ No | Rheumatism | ○ Yes ○ No |
| Arthritis/Gout | ○ Yes ○ No | Epilepsy or Seizures | ○ Yes ○ No | High Cholesterol | ○ Yes ○ No | Scarlet Fever | ○ 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 | Sickle Cell Disease | ○ 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 |
| Leukemia | ○ 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 |
| Swelling of Limbs | ○ 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 | Heart Pacemaker | ○ Yes ○ No | Parathyroid Disease | ○ Yes ○ No |
| Ulcers | ○ Yes ○ No | Convulsions | ○ Yes ○ No | Heart Trouble/Disease | ○ Yes ○ No | Psychiatric Care | ○ Yes ○ No |
| Yellow Jaundice | ○ Yes ○ No | | | | | | |

Have you ever had any serious illness not listed ○ 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:_____

**Thank you for choosing our practice to provide your dental care…**

We are committed to high quality care to our patients. Our goal is to help you reach the best oral health possible so you can enjoy the benefits of a comfortable, functional, and attractive smile.

**Dental Insurance**
It is important to remember that your insurance coverage is a contract between you, your employer, and your insurance company. Benefits and coverage vary significantly from plan to plan. Please keep in mind that insurance is not designed to provide 100% benefit, but rather is meant to assist you with the cost of dental care.

As a courtesy to our patients, we are happy to submit your claims for services. In order for us to do this, you must provide us with accurate and up-to-date insurance information. We will verify your coverage and plan before your appointment. With this, we will estimate the insurance portion and your co-payment. This may or may not be what the insurance company will actually pay. Your plan may base its dollar allowance on a usual and customary fee schedule which may not coincide with current fees in our area. We'll do our best to help you receive maximum benefits. We participate with Delta Dental PPO, Cigna PPO and United Health Care PPO. Patients are responsible for all balances incurred for services received.

We will wait 45 days for insurance claims to be paid. After 45 days if payment has not been made, you will be asked to pay the balance and seek reimbursement from your insurance company.

**Payment for Services**
Payment is expected at the time of your services. If you have dental insurance, we will provide an estimate of your co-payment and collect your portion at the time of your appointment. We accept cash, checks, Visa, MasterCard, Discover. We also offer Care Credit, an outside healthcare financing program that offers interest-free payment plans upon approval.

A late fee of 1.6% will be assessed monthly to accounts after 60 days. Any unpaid balance over 90 days will be considered delinquent and turned over to a collection agency. Fees may apply. Returned check fee is $35.00.

**Minor Patients**
Please plan to be present at appointments with your child under 18. If you cannot be there, please make prior arrangements with our staff. The parent accompanying the minor child is responsible for payment. In the case of a divorce, regardless of decree, the parent who brings the child and has signed the financial agreement is responsible to pay for the child's services. We are unable to bill separate parties; therefore parents can work out these details.

We understand that sometimes it is necessary to change your appointment. We ask that you kindly allow 2 business days when needing to alter any reserved appointment. Without this notice, we are unable to offer treatment to other patients that may have needed our care. If 2 or more appointments are broken in a 12 month period without 2 business days notice, all future appointments will be cancelled and patients will be placed on a "priority list" for their next visit. Cancellation fee of $50.00 may be applied.

I have read and understand my obligation:

Signature (patient/guardian):

_____ Date:_____

HEIDRICH & HEIDRICH
GENERAL & FAMILY DENTISTRY

# Dental History

Patient's Name:_____

Former Dentist: _____ Phone: ( ) _____

Address: _____City:_____State: _____ Zip: _____

Date of last dental care:_____ Date of last x-rays:_____

What would you like us to do today?_____

Are you in dental discomfort today? : __ yes __ no

Check if you have had problems with any of the following:

__bleeding gums
__loose teeth or broken fillings
__clicking or popping jaw
__periodontal treatment
__food collecting between teeth
__reaction to anesthesia
__grinding or clenching teeth
__sores or growths in mouth
__sensitivity to hot
__sensitivity to cold
__sensitivity to sweets
__sensitivity to biting

How often do you brush? _____ Floss?_____

How do you feel about the appearance of your teeth? _____

Have you ever experienced and adverse reaction during or in conjunction with a dental procedure? __yes __ no

Other information about your dental health or previous treatment:_____

Heidrich & Heidrich, D.M.D.

1950 Mizell Ave.

Winter Park, FL 32792

Phone: 407-644-4441

## ACKNOWLEDGEMENT OF PRIVACY PRACTICES

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (I-IIPPA). 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 providers Notice of Privacy Practices containing a more complete description of the uses and disclosure 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 has 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. Also, I understand that you (Dr.'s Heidrich) are not required to agree to my requested restrictions, but if you do agree, than you (Dr.'s Heidrich) are bound to abide by such restrictions.

Patient Name: _____ Date: _____

Signature: _____

Relationship to patient: _____

List any dependent family members authorizing Dr.'s Heidrich and staff to discuss any/all treatments including fees and finances with the following person(s):

_____

_____

For Office Use Only: We were unable to obtain the patients written acknowledgement of our Notice of Privacy Practices due to the following reason: The patient refused to sign, communication barriers, emergency situation, other.