PATIENT REGISTRATION

ID: _____ Chart ID: _____

First Name: _____ Last Name: _____ Middle Initial: _____

Patient Is: ☐ Policy Holder Preferred Name: _____

☐ Responsible Party

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

Student Status: ◯ Full Time ◯ Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

Additional Comments:

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: _____.00 Rem. Deduct: _____.00

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: _____.00 Rem. Deduct: _____.00

Podvia _Stanford DMDs

Eaglesoft Medical History(Updated 07/27/2017)

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
Have you taken any Erectile Dysfunction Medication?	Yes No	

(Note this can effect medications given during appointments, please notify the doctor/assistant if you have used any Erectile Dysfunction medication within 48hours prior to any appointments)

Have you had the Shingles Vaccine? If yes, please provide the approximate dates	Yes No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Please be advised that if you are prescribed an antibiotic it can reduce the effect of oral contraceptives. Please Initial _____

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	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	Spina Bifida	Yes No
Blood Transfusion	Yes No	Frequent Diarrhea	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	Genital Herpes	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	Venereal Disease	Yes No
Yellow Jaundice	Yes No	Acid Reflux	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:_____

Medication Form Todays date: ____/____/____

Name: _____ **Date of Birth:** ____/____/____

Primary Care Physician: _____ Phone#: _____

Allergic to/Describe Reaction:

1.	
2.	
3.	
4.	

❒"Currently Not Taking Medications"

Please LIST ALL MEDICINES YOU ARE CURRENTLY TAKING: Prescription and over-the-counter medications (examples: aspirin, antacids), dietary supplements, and herbals (Examples: ginseng, gingko). Include medications taken as needed (Example: nitroglycerin, vitamins, hemopathic remedies).

Name of Medication	Dose	Reason for taking

Podvia Stanford FAMILY DENTISTRY

Dental Health Information For: _____

Thank you for providing us with important information that will help us serve you better.

Are you having any discomfort? ☐ Yes ☐ No

If yes, for how long & please describe: _____

When was your last cleaning? _____

Have you ever had an oral cancer exam? If yes, when was it last done? _____

How often do you brush your teeth? _____ For how long? _____ Floss? _____

Do you smoke or use tobacco in any form? ☐ Yes ☐ No

What beverages do you drink during the day- and how much? (Like sodas, sweet tea, Gatorade, etc.)

_____

Does dental treatment make you nervous? ☐ Yes ☐ No

Have you experienced any of the following problems?

Bleeding gums	☐ Yes	☐ No
Bad breath	☐ Yes	☐ No
Headaches	☐ Yes	☐ No
Grinding your teeth	☐ Yes	☐ No
Snoring	☐ Yes	☐ No
Do you use a CPAP machine	☐ Yes	☐ No

Have you ever thought about straightening your teeth?	☐ Yes	☐ No
Have you ever thought about whitening your teeth?	☐ Yes	☐ No

If you could change anything about your teeth- What would that be?

Close spaces	☐ Yes	☐ No
Repair chipped teeth	☐ Yes	☐ No
Replace missing teeth	☐ Yes	☐ No
Be able to chew better	☐ Yes	☐ No
Replace old crowns or caps that don't match	☐ Yes	☐ No
Replace silver or black fillings with tooth colored ones	☐ Yes	☐ No

Today's Date: _____/_____/_____

(Signature of patient or legal guardian) _____

Podvia & Stanford Family Dentistry

Your Privacy Is Important to Us

Acknowledgement of Receipt of Notice of Privacy Policies

I have received a copy of the Notice of Privacy Practices of Podvia & Stanford Family Dentistry. I hereby authorize, as indicated by my signature below, Podvia & Stanford Family Dentistry to use and to disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form.

_____ _____

Print Name Address

_____ _____

Signature Date

Please check your preferred means of communication:

☐ You may contact me at my home telephone number _____

☐ You may contact me on my mobile telephone number _____

☐ You may contact me on my work telephone number _____

☐ You may send me an unencrypted email/text message at: _____

☐ Other _____

Please list authorized persons with whom we may discuss your Protected Health Information (PHI) in addition to custodial parents and legal guardians:

1. _____Date Added / Removed:_____

2. _____Date Added / Removed: _____

3. _____Date Added / Removed: _____

4._____Date Added / Removed: _____

* * *

For 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 the acknowledgement

☐ Other (Please Specify) _____

Staff Person Initials _____

INFORMATION FOR OUR PATIENTS WITH DENTAL INSURANCE

Dental insurance is playing a larger role in helping people obtain dental treatment. Since we feel strongly that our patients deserve the best dental care we can provide, and in an effort to maintain a high quality of dentistry, we would like to share some facts about dental insurance with you.

We consider our relationship with you to be of primary importance and will always be making our recommendations to you based on what we believe is the very best treatment for you regardless of your insurance coverage. As the patient, it is your responsibility to deal with your insurance company and your employer. We will assist in any way possible to maximize your dental insurance benefits but to reemphasize; we have no relationship or responsibility to your insurance company.

Fact 1: Dental Insurance is not meant to be a "PAY ALL" it is only meant to be an aid

Fact 2: Many plans tell their insured that they will be covered up to 80-100%. In spite of what you're told, we've found many plans cover 40-50% of an average fee. Some plans pay more…some pay less. The amount your plan pays is determined by the contribution you and your employer make to your dental plan. The smaller the contribution paid into the plan for "insurance", the less you'll receive. It is your responsibility to advise us of your insurance coverage and restrictions

Fact 3: It has been the experience of many dentist that some insurance companies tell their customers that "fees are above the usual and customary fees" rather than saying to them that "our benefits are low". Remember you get back only what you and your employer put into your insurance coverage less the profits of the insurance company. In dealing with over 1000 dental insurance plans, most plans do cover our fees at the "stated" percentages

Fact 4: Each plan utilized in our office has different percentages, deductibles, maximums, procedures covered, and varying fees that the plan will allow. We will do our very best to make a close a calculation as possible of what your insurance plan will cover. However, as we cannot estimate precisely, there may be variances

Fact 5: Many routine dental services are NOT covered by insurance carriers. We make our recommendations based on your needs and not on what your insurance may or may not cover.

Please do not hesitate to ask us any questions about our office protocol. We want you to be comfortable in dealing with these matters and we urge you to consult us if you have any questions regarding our service or fees. We will fill out and file insurance forms at no charge. We will do all we can to assure you of your maximum benefits.

If you have any questions regarding your insurance, please contact your insurance carrier regarding the specifics and details of the plan they are operating on your behalf.

- ∞ I authorize the release of all necessary information
- ∞ I authorize payment of benefits directly to the provider
- ∞ I have read this form and agree to be financially responsible for all fees regardless of coverage.

_____ _____/_____/_____

Patient Signature **Date**

_____ _____/_____/_____

Office Policies

Changes and Cancellations:

_____ All reservations are reserved exclusively for each patient. To accommodate all patients, we ask for 48 hours' notice for any changes or cancellations with reservations. Our office will reach out to you via text, email and/or phone call in advance to have a verbal confirmation. If for any reason you need to change your reservation please call our office directly 48 hours prior to your reservation, so that we may offer the reservation to a patient that is waiting to come sooner. Failure to do so may result in a charge per hour and also may result in a patient not being seen in a timely manner.

_____ Late arrival for your reservation may result in not being able to complete all care that was needed- or that we may need to reschedule. It may also result in a charge for missed reservation.

_____ We do recognize that emergencies do sometimes occur, but we ask for your help with making limited reservation changes. Excessive reservation changes and/or cancellations will be reviewed on a case by case basis and may result in termination of our relationship and service.

Payments and Insurance:

_____ Payment is due in full at the time of treatment. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment, deductibles or fees that my insurance does not cover.

_____ In the unlikely event of default- and financial arrangements have not been made, then the patient or responsible party is responsible for any and all legal collection as well as attorney's fees. There will be a $35.00 charge for any returned check due to insufficient funds. I understand interest of 18% per annum (1.5% monthly) may be charged on account over 30 days delinquent.

_____ As a courtesy we will submit your insurance claims for you and accept assignment of benefits. It is in your best interest to know exactly what services are provided by your insurance plan. We do want to help you receive your maximum benefits; however we do not have any power to force an insurance company to pay. You and your employer/group benefits administrator have signed into a contract with the insurance company- and have the power to move them forward with any claim/appeal process. We submit insurance daily and resubmit if payment has not been received within 30 days and again in 60 days with a letter to the insurance commissioner. Any balance unpaid by the insurance company after 61 days becomes the responsibility of the patient and we ask that it be paid at that time. We will continue to assist you in obtaining reimbursement from your insurance carrier.

_____ In order to assist you with proper identification for each appointment, we will need to copy the front and back of your insurance card, picture identification and we will ask to take a photo for your chart upon arrival.

Authorizing Treatment and Assignment of Benefits:

_____ I hereby authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with the dental care of the patient above, and further authorize and consent that the doctor chooses and employs such assistance as he/she deems fit. I also understand that previous to treatment the doctor and or his/her staff will give a full explanation of the procedure(s) involved. I agree to pay for all services rendered by this office.

_____ I hereby authorize Dr. Podvia & Dr. Stanford to release to my insurance company, any information acquired in the course of my dental care. I hereby authorize benefits to be paid directly to Dr. Podvia & Dr. Stanford. I understand I am responsible for any unpaid balance.

Initialing above and your signature below indicates that you have read and have understanding of the above policies. You acknowledge that you have been given the opportunity to ask questions, receive clarification and you are accepting of the policies.

X _____ Date_____

Signature of Patient/Insured

PHOTOGRAPHY MODEL RELEASE

I consent to allow Podvia & Stanford Family Dentistry to use my photos, dental photos, radiographs and study models from my dental record for website marketing, scientific papers, lectures, demonstrations or educational events. I assign to Dr. Podvia, Dr. Stanford and Dr. Erbesti the copyright and/or right to copyright such photographs taken, and the right of reproduction in the use of patient education, case publishing, practice marketing including print media, website in any manner, including the right of necessary retouching and tinting or work up for reproduction purposes. I understand that I have voluntarily allowed my photograph to be made, and that I will receive no compensation, financial or otherwise, for posing or for allowing my photographs to be reproduced. I hereby waive any right to approve the finished photograph, or any copy, which might be used in conjunction with the finished photograph. This consent may be revoked by written notice delivered to Podvia & Stanford Family Dentistry within 30 days of signature.

I have been informed that I am not required to sign this consent. If declining this consent, leave blank.

Please initial one option:

____ I authorize my photographs to be used as stated above.

____ I authorize photographs of my teeth (no full face photos) to be used as stated above.

Patient name (printed): _____

Signature (patient or guardian/parent): _____

Date: _____

Authorized Team Member: _____