DATE

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

EMPLOYER

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:

Date

David M Hagel DDS, Evident Alliance

Eaglesoft Medical History

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.

Question			
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

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

Other? If yes

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

Condition			Condition			Condition			Condition		
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	Tonsilitis	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

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:__________

Village Dentistry
Dr. David M. Hagel, D.D.S.

Acknowledgement of Financial Policies

Welcome to Dr. David Hagel's office at Village Dentistry. Our practice is committed to providing you and your family with safe, gentle, high-quality dental care. Providing comprehensive dental services includes discussing treatment and financial information before treatment is performed so you can anticipate fees you may owe and make financial arrangements as necessary. If we fail to do this, please ask.

Insurance

As a courtesy to our patients using dental insurance, Dr. Hagel's office submits your insurance claim on your behalf and assists you in maximizing the dental benefits provided by your insurance provider. Policy coverages, eligibility, and follow-up on unpaid claims are ultimately your responsibility. On the date of your office visit, you are responsible for your deductible and the portion we estimate that your insurance does not cover. If insurance coverage cannot be verified prior to treatment, you will be responsible for the full amount of rendered services on the date that treatment was provided.

Any quoted amount for dental services is always an estimate and is subject to change.

If your insurance company has not made a payment within 60 days of billing, the balance will become your responsibility (insurance is a contractual agreement between the insurance company and your employer. Dr. Hagel's office has no control over this relationship).

Cash and Senior Discounts

We offer a 5% discount for in-full cash, check, or debit card payments at the time of treatment. Seniors (age 60 & older) receive an additional 5% discount when paying for treatment, in-full, at the time of service. Cash and senior discounts are not applicable with dental insurance.

Treatment Plan Changes

Changes to treatment can change during your procedure. The patient is responsible for any monetary differences in the services rendered. Additional treatment cannot be schedule for patients with an outstanding balance.

Reschedule and Cancellation Policy

48 business hour's notice for cancellations and rescheduling of appointments is needed to avoid a $60.00 fee. Two consecutively missed appointments may require up-front payment for your next appointment.

Collections and Finance Charges

Accounts without payment activity in 90 days may be handed to a collection agency. Outstanding balances will accrue a monthly finance charge starting 30 days from the date of service. A $30 fee will be assessed for any returned checks.

Consent & Authorization

I have read and understand the financial policies of Dr. Hagel's office. By receiving treatment for myself or for my dependents, I authorize and accept responsibility to pay for such treatment. Fees not covered by my dental insurance will be promptly paid upon notification from this office. Without any reservation, I agree to abide by these policies.

______________________________	______________________________
Name of Patient or Personal Representative	Signature of Patient or Personal Representative
______________________________	______________________________
Date	Description of Personal Representative's Authority

ACKNOWLEDGEMENT
OF
PRIVACY PRACTICES

Village Dentistry
Dr. David M. Hagel D.D.S.
23515 NE Novelty Hill Rd. #209
Redmond, WA 98053
(425)898-7780

I give this practice my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

I understand that I may review practice's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I understand that this practice has the right to change their privacy practices and that I may obtain my revised notices at the practice.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment of health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature: ________________________________ Date:______________
Patient, parent or legal guardian

If signed by patient representative, state relationship to patient ____________________

Dependent family members also covered by this acknowledgement:

____

For Office Use Only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practice due to the following reason:

- o The patient refused to sign
- o Communication barrier
- o Emergency situation
- o Other