Patient Registration

First Name/ Preferred Name: _____ Last Name: _____ Middle Initial: _____

Patient is: ◯ Policy Holder ◯ Responsible Party

Responsible Party (if someone other than the patient)

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

Address: _____ Address 2: _____

City, State, Zip: _____ Work Phone: _____ Extension: _____

Cell Phone: _____ Email: _____ Email Me: ◯ Yes ◯ No

Birth Date: _____ Social Security Number: _____ Drivers License: _____

◯ Responsible Party is also a Policy Holder for Patient ◯ Primary Insurance Policy Holder ◯ Secondary Insurance Policy Holder

Patient Information

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

Address: _____ Address 2: _____

City, State, Zip: _____ Work Phone: _____ Extension: _____

Cell Phone: _____ Email: _____ Email Me: ◯ Yes ◯ No

Birth Date: _____ Social Security Number: _____ Drivers License: _____

Employment Status: ◯ Full-Time ◯ Part time ◯ Retired

Student Status: ◯ Full-Time ◯ Part time ◯ On-Leave

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hygienist: _____

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. Deduc: _____.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. Deduc: _____.00

How'd You Hear About Us?

◯ Facebook ◯ Instagram ◯ Yelp ◯ Visited our Website ◯ Recommended by a Current Patient: _____

Medical History

Patient Name: _____ Birth Date: _____

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 Please Explain: _____
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If Yes Please Explain: _____
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If Yes Please Explain: _____
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If Yes Please Explain: _____
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If Yes Please Explain: _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If Yes Please Explain: _____
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	
Do you use controlled substances?	◯ 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 ◯ Codeine ◯ Latex ◯ Local Anesthetics ◯ Sulfa Drugs
◯ Other If yes, please explain: _____

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

◯ AIDS/HIV Positive	◯ Chest Pains	◯ Frequent Headaches	◯ Irregular Heartbeat	◯ Scarlet Fever
◯ Alzheimer's Disease	◯ Cold Sores/Fever Blisters	◯ Genital Herpes	◯ Kidney Problems	◯ Shingles
◯ Anaphylaxis	◯ Congenital Heart Disorder	◯ Glaucoma	◯ Leukemia	◯ Sickle Cell Disease
◯ Anemia	◯ Convulsions	◯ Hay Fever	◯ Liver Disease	◯ Sinus Trouble
◯ Angina	◯ Cortisone Medicine	◯ Heart Attack/Failure	◯ Low Blood Pressure	◯ Spina Bifida
◯ Arthritis/Gout	◯ Diabetes	◯ Heart Murmur	◯ Lung Disease	◯ Stomach/Intestinal Disease
◯ Artificial Heart Valve	◯ Drug Addiction	◯ Heart Pace Maker	◯ Mitral Valve Prolapse	◯ Stroke
◯ Artificial Joint	◯ Easily Winded	◯ Heart Trouble/Disease	◯ Pain in Jaw Joints	◯ Swelling of Limbs
◯ Asthma	◯ Emphysema	◯ Hemophilia	◯ Parathyroid Disease	◯ Thyroid Disease
◯ Blood Disease	◯ Epilepsy or Seizures	◯ Hepatitis A	◯ Psychiatric Care	◯ Tonsillitis
◯ Blood Transfusion	◯ Excessive Bleeding	◯ Hepatitis B or C	◯ Radiation Treatments	◯ Tuberculosis
◯ Breathing Problem	◯ Excessive Thirst	◯ Herpes	◯ Recent Weight Loss	◯ Tumors or Growths
◯ Bruise Easily	◯ Fainting Spells/Dizziness	◯ High Blood Pressure	◯ Renal Dialysis	◯ Ulcers
◯ Cancer	◯ Frequent Cough	◯ Hives or Rash	◯ Rheumatic Fever	◯ Venereal Disease
◯ Chemotherapy	◯ Frequent Diarrhea	◯ Hypoglycemia	◯ Rheumatism	◯ Yellow Jaundice

Comments: _____

Last Dental Visit: _____ Last Dental Cleaning: _____ Last Set of X-Rays: _____

Name of Medical Doctor: _____ Phone Number: _____

In case of Emergency who should we contact? _____ Relationship to Patient: _____

Home #: _____ Work #: _____ Cell#: _____

General Consent

Treatment Consent

The undersigned hereby authorizes this office to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Hopkins, and or Dr. Quan, to make a thorough diagnosis of the patient's needs. I also authorize these Dr's to perform any and all forms of treatment, medication and therapy, that may be indicated and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand that the use of anesthetic agents embodies a certain risk.

Please give 48 hour notice to avoid broken appointment charge.

Financial Consent

I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered. I further understand that a billing charge will be added to any balance over 60 days. In the event of default, I (we) promise to pay legal interest on the indebtedness, together with such collections costs and reasonable attorney fees that may be required to effect collection of the note.

Insurance Consent

I hereby authorize the office of Michael Z. Hopkins & Dr Robert Quan, to affix my name to any and all claims or documents as related to any and all health benefits due me. I authorize the release of any medical information necessary to process claims. I also authorize payment of dental benefits, otherwise payable to me, directly to Dr. Michael Hopkins. This office will submit charges to the primary insurance carrier as a courtesy to the patient. Any charges that have not been paid within 60 days of treatment from the third party carrier will be the patient's full responsibility. I am also aware that insurance is not a guarantee of benefits and I will be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. I will make any corresponding copayments at the time of service. I have been offered a copy of the Notice of Privacy Practices for the office of Michael Z. Hopkins, D.D.S. as required by HIPAA.

Additionally, I acknowledge receipt of the Dental Materials Fact Sheet dated May 2004.

Patient Signature: _____

Financial Policy

Thank you for choosing our practice to serve your dental needs. Please take the time to read the following, initial each section, and sign and date the bottom of this form.

_____ Full payment is due at the time of service unless arrangements have been made prior to the start of any treatment.

_____ Insurance balances are ultimately the patient's obligation. We will file most primary insurances at no cost to you as a courtesy. However, insurance balances which are not paid within 60 days may be billed to you. Please keep your walk-out statements and follow up with your insurance carrier to ensure prompt payment.

_____ Some of your treatment may NOT be covered by your insurance carrier. The cost for such charges will be your responsibility.

_____ Major services may require a deposit equal to at least one half of the estimated patient portion at the time the appointment is made.

_____ Patient's are asked to confirm their appointments at least 48 hours in advance by directly contacting our office or by responding to our confirmation contact. Failure to confirm your appointment may result in a charge for the time reserved.

_____ There will be a fee of $30.00 for any checks returned as a Non-Sufficient Funds (NSF)

_____ Patient's balances that go unpaid for 30 days or more may incur one or more of the following charges, $25.00 monthly service charge for billing or 1.5% per month on unpaid balances. Legal fees for collection services.

Signature of Patient or Guardian: _____ Date: _____