REGISTRATION AND TREATMENT

Cell Phone_____

Date_____ Email_____Home Phone _____

PATIENT INFORMATION

Name _____ Soc. Sec # _____
Last Name First Name Middle Initial

Address_____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Birthdate_____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed By _____ Occupation _____

Business Address _____ Business Phone_____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Middle Initial

Relation to patient_____ Birthdate _____ Soc. Sec # _____

Address (if different from patient) _____ Phone _____

City _____ State _____ Zip _____

Person Responsible Employed By _____ Occupation _____

Business Address _____ Business Phone_____

Insurance Company _____

Contract # _____ Group #_____ Subscriber #_____

Names of other dependents covered under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____
Last Name First Name Middle Initial

Relation to patient_____ Birthdate _____ Soc. Sec # _____

Address (if different from patient) _____ Phone _____

City _____ State _____ Zip _____

Subscriber Employed By _____ Business Phone _____

Insurance Company _____

Contract # _____ Group #_____ Subscriber #_____

Names of other dependents covered under this plan _____

Crestview FAMILY DENTAL

Patient Name _____

DENTAL HISTORY

Reason for today's visit_____

Previous Dentist _____

Address_____

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

How often do you floss? _____ How often do you brush? _____

Is there anything you dislike or would like to change about your teeth, bite or smile? _____

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

□ Bad Breath	□ Grinding teeth	□ Sensitivity to hot and/or cold	□ Sensitivity to sweets
□ Sensitivity to biting	□ Bleeding gums	□ Periodontal treatment	□ Loose teeth
□ Clicking/popping jaw	□ Broken fillings	□ Food collection between teeth	□ Sores or growths in your mouth

MEDICAL HISTORY

Physician's Name _____ Date of last visit_____

Have you had any serious illnesses or operations? □ Yes □ No If yes, describe _____

Do you bruise easily? □ Yes □ No

Have you ever had a blood transfusion? □ Yes □ No If yes, give approximate dates _____

(Women) Are you pregnant? □ Yes □ No Nursing? □ Yes □ No Taking birth control pills? □ Yes □ No

Check (√) if you have or have had any of the following:

□ AIDS	□ Cortisone Treatments	□ Hepatitis B or C	□ Respiratory Disease
□ Anemia	□ Cough, Persistent	□ High Blood Pressure	□ Rheumatic Fever
□ Angina	□ Cough up blood	□ HIV Positive	□ Scarlet Fever
□ Arthritis, Rheumatism	□ Diabetes	□ Kidney Disease	□ Shortness of breath
□ Artificial Heart Valves	□ Down's Syndrome	□ Learning Disability	□ Skin Rash
□ Artificial Joints	□ Epilepsy	Describe _____	□ Stroke
□ Asthma	□ Fainting	□ Mental Health Conditions	□ Swelling of feet or ankles
□ Autism	□ Glaucoma	Describe _____	□ Thyroid Conditions
□ Blood Disease	□ Headaches	□ Mitral Valve Prolapse	□ Tobacco habit
□ Cancer	□ Heart Murmur	□ Nervous Conditions	□ Tonsillitis
□ Chemical Dependency	□ Heart Conditions	□ Pacemaker	□ Tuberculosis
□ Chemotherapy	Describe _____	□ Psychiatric care	□ Ulcer
□ Circulatory Conditions	□ Hemophilia	□ Radiation Treatment	□ C Pap/Sleep Apnea
□ Recreational Drugs	□ Osteoporosis	□ Alzheimers	□ Dementia

MEDICATIONS

_____

_____

_____

ALLERGIES

_____

_____

_____

DENTAL HISTORY

- I authorize my insurance company to pay to the dental office all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.
- I authorize the dentist to release all information necessary to secure the payment of benefits.
- I understand that I am financially responsible for all charges whether or not they are paid for by insurance.

Signature _____ Date _____

Payment is due in full at time of treatment unless prior arrangements have been approved.

Crestview
FAMILY DENTAL

HIPAA

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
AND
CONSENT / AUTHORIZATION / RELEASE FORM

The undersigned acknowledges receipt of a copy of this healthcare facility's currently effective Notice of Privacy Practices. A copy of this document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A RECORDS RELEASE SHOULD I REQUEST THEY BE SENT TO OTHER DOCTORS / PRACTICES

_____ _____

Please ***print the*** name of Patient ***Signature*** of Patient, or Guardian of Patient

_____

Date

_____

Please print name of Guardian/Legal Representative and Relationship

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:

Name:_____Relationship: _____

Name:_____Relationship: _____

Name: _____Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO
CONFIRM MY APPOINTMENTS, TREATMENT, HEALTH, or BILLING INFORMATION VIA

_____ Home/Cell Phone

_____ Work Phone

_____ Text or Email

Office e-mail: info@crestviewfamilydental.com
1810 Crest View Dr, Ste 5A
Hudson, WI 54016

715-386-3727

Welcome to Crestview Family Dental

Thank you for selecting us as your dental health care providers. Our goal is to provide you and your family with optimal dental care. We want you to feel welcome and as comfortable as possible throughout your treatment. We encourage you to ask questions and to be involved in treatment decisions.

Financial Policy

Payments: Payment is due at the time services are rendered unless prior arrangements have been made with the business manager. All insurance co-pays and deductibles must be paid at the time of service.

- Payment options: We accept Cash, Check, Visa, MasterCard, Discover & American Express.
- Monthly payment options: Through CareCredit we offer interest-free term loans with no down payment, annual fee, or prepayment penalty

Insurance: Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event we do accept assignment of benefits and your insurance company has not paid your account in full within 60 days, the balance may be transferred to your account. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and customary under the terms of your insurance policy. Our practice is committed to providing the best treatment for our patients and we charge what is the usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

***Please note:** Some insurance companies will not pay for composite (white fillings) on posterior teeth. Instead, they pay their allowance for an amalgam (mercury fillings). You are responsible for the difference. Please, keep in mind that Dr. Anderson does not do amalgam fillings.

Missed appointments: In order to serve you better and keep the cost of dental care down, we try to maintain an efficient appointment system. However, our cost of providing care increases greatly when patients fail to keep an appointment. We reserve the right to charge a fee for canceled or missed appointments without **48 hours notice**.

Service Charges: Unpaid balances will be assessed a finance charge of 18% per annum after 60 days. Checks that are returned to our office from your financial institution are subject to a $35.00 returned check fee.

Dispute Resolution: This agreement shall be interpreted, governed and enforced according to the laws of the State of Wisconsin. Any dispute arising out of this agreement shall be resolve through arbitration or legal actions in St. Croix County, Wisconsin.

Consent for services Consent to Diagnostic Records: I hereby give permission to Dr. Jennifer Anderson and qualified staff to take and use diagnostic records for the purpose of planning treatment. These records can include photographs, radiographs, impressions, and plaster study models, and medical/dental history.

Insurance Payment Authorization: I hereby authorize payment to Crestview Family Dental for the group insurance benefits otherwise payable to me by Dr. Jennifer Anderson and/or hygienist. I authorize records to be released to the insurance as requested by them to effectively process claims.

Please indicate your understanding and acceptance of these policies by signing below. For the mutual convenience of you and the practice, it is understood that this executed copy shall also cover any dependent children who are patients of the practice.

Patient name (printed): _____

Signature of Patient or Responsible Party: _____ Date: _____

Crestview Family Dental
Dr. Jennifer Anderson
1810 Crestview Drive, Suite 5A
Hudson, WI 54016
Phone: 715-386-3727
Fax: 715-386-4029
Email: info@crestviewfamilydental.com

PATIENT AUTHORIZATION FOR RELEASE OF PROTECTED RECORDS

Today's Date: _____

Patient Name & DOB: _____

Reason for leaving the practice: _____

I AUTHORIZE THE DISCLOSURE AND USE OF DENTAL HEALTH INFORMATION/RECORDS TO THE FOLLOWING:

Facility Name: _____

Facility Email Address: _____

Facility Phone Number: _____

Names of other family members (minors) whose records may also be included for the above act:

_____ _____

_____ _____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN OF MINOR:

_____