TenderCare Clinic

REGISTRATION FORM

Today's Date ____/ _____ / _____ (Please Print) Account Number: _____

PATIENT INFORMATION

Patient's Last Name	First	Middle	☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	Former Name

Street Address	City	State	ZIP Code

Mailing Address if different than Physical Address	City	State	ZIP Code

Home Phone ( )	Cell Phone ( )	Name of Employer	Work Phone ( )

Birth Date / /	Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated	Social Security ____ - ___ - ____

Sexual orientation
- ☐ Straight or heterosexual
- ☐ Lesbian, gay, or homosexual
- ☐ Bisexual
- ☐ Other _____
- ☐ I don't know
- ☐ Choose not to disclose

Gender
- ☐ Male
- ☐ Female
- ☐ Gender Queer
- ☐ Choose not to disclose
- ☐ Transgender Female/ Male-to-Female
- ☐ Transgender Male/ Female-to-Male
- ☐ Other _____

Email Address

ADDITIONAL PATIENT INFORMATION

Race
☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Other
☐ Black/African American ☐ White ☐ American Indian/Alaska Native

Ethnicity
☐ Hispanic or Latino
☐ Non-Hispanic or Latino

Language Best Spoken ☐ English ☐ Spanish ☐ Other_____	Homeless ☐ Yes ☐ No	Public Housing Patient ☐ Yes ☐ No

Family Size ☐ _____ ☐ Choose not to disclose	Income ☐ $_____ ☐ Choose not to disclose	Veteran ☐ Yes ☐ No ☐ Choose not to disclose	Student Status ☐ FT ☐ PT ☐ Not a student	Agricultural Worker ☐ Yes ☐ No

RESPONSIBLE PARTY / PARENT / GUARDIAN

Responsible Party / Guardian / Parent	Relationship to Patient	Birth Date / /

Street Address	City	State	ZIP Code	Home Phone ( )

Employer	Employer Address	Employer Phone ( )

INSURANCE INFORMATION

Is this patient covered by Insurance? ☐ Yes ☐ No

Primary Insurance Name	Subscriber Name	Subscriber DOB	Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other _____
Secondary Insurance Name	Subscriber Name	Subscriber DOB	Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other _____

EMERGENCY CONTACT (OTHER THAN PARENT, GUARDIAN, REPSONSIBLE PARTY)

Name of Local Friend or Relative	Relationship to Patient	Home Phone ( )	Cell Phone ( )
Name of Local Friend or Relative (not living at the same address)	Relationship to Patient	Home Phone ( )	Cell Phone ( )

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ADDITIONAL INFORMATION			
Do you have a preferred pharmacy? ☐ Yes ☐ No	Pharmacy Name	Pharmacy Location	Pharmacy Phone ( )
Other Family Members Seen Here:			
Chose Clinic Because / Referred to Clinic By (Please check one box): ☐ Dr. _____ ☐ Hospital _____ ☐ Family _____ ☐ Friend _____ ☐ Internet ☐ Phone Book ☐ Other _____			

_____Initial CONSENT FOR TREATMENT: I authorize TenderCare Clinic and such assistants as they may designate, to carry out diagnostic procedures, if needed, to better diagnose my condition and to administer such treatments and medication, as indicated. I understand that my condition may call for a consultation with another physician, dentist or specialist. If the necessity for consultation arises, I authorize TenderCare Clinic to release medical information needed improve the medical and dental treatment I receive.

_____Initial ASSIGNMENT OF BENEFITS: I authorize my insurance company to pay directly to TenderCare Clinic the cost allowable and otherwise payable to me under my insurance policy, applicable to the professional services rendered. I agree to pay all charges not covered by insurance payments. If I receive the claim payment from my insurance company, I will forward the payment to TenderCare Clinic within one week.

_____Initial PAYMENT AGREEMENT: Contact information, registration data and my health history are all complete and true to the best of my knowledge. I request TenderCare Clinic to provide me and/or my family with medical and dental care. I acknowledge my responsibility to pay for services according to the policies established by TenderCare Clinic.

_____Initial NO SHOWS AND CANCELLATIONS: I have received a copy of the No Show & Cancellations Policy, and I understand I must keep my appointments, or give 24 hours advance cancellation notice. If I violate the policy, I understand I will receive a appointments for a day only, and receive treatment as time permits.

_____Initial NOTICE OF PRIVACY PRACTICES: I have received the Notice of Health Information Practices from TenderCare Clinic. I have read and reviewed the notice. All of my questions were answered to my satisfaction.

_____Initial DENTAL OFFICE POLICIES: I have received the Dental Clinic Policies. I have had the opportunity to read, review and ask questions regarding the Dental Clinic Policies. I understand that violation of the office policies may result in my immediate removal from the premises or my dismissal as a patient.

I have been provided a copy of the "No Show & Cancellation Policy," "Notice of Privacy Practices" and "Dental Office Policies." I have had the opportunity to ask questions regarding the consent, agreements and policies outlined above.

Patient/Guarantor Signature _____ *Date* _____

Front Office Signature _____ *Date* _____

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Medical & Dental History Form

DENTAL HISTORY

Patient's Name: _____

Why have you come to the dentist today?

_____

_____

_____

Are you currently in pain?

Y N

Do you require antibiotics before dental treatment?

Y N Not Sure

Your current dental health is:

Good____ Fair____ Poor____

Do you floss daily? Y N

Brush daily? Y N

Do you wear dentures or partials? Y N

Do you have any loose teeth?

Y N

Are your teeth sensitive to heat or cold?

Y N

Do you grind (or "brux") your teeth?

Y N

Who was the last dentist you visited?

_____

Last visit date: _____/_____/_____

Was that a routine, check-up visit?

Y N

Are you happy with the way your smile looks?

Y N

If not, what would you change?

_____

MEDICAL HISTORY

Are you currently under the care of a physician?

Y N

Physician's Name:

_____

Address:

_____

City *State*

Phone #: (_____)_____

Date last visited: _____/_____/_____

Do you use tobacco? Circle all that are true:

Smoke Chew Other

No/Never Have No/Used To

Do you drink alcohol? Y N

About how much per week?_____

Do you use illicit drugs currently? Y N

Are you allergic to any of the following?

Barbiturate/sedative	Y	N	Latex	Y	N
Dental Anesthetics	Y	N	Aspirin	Y	N
Penicillin	Y	N	Jewelry/Metals	Y	N
Codeine/Opioids	Y	N	Sulfa Drugs	Y	N
Other	Y	N			

Please list additional drugs/materials that cause allergic reactions: _____

_____

_____

_____

For Women: Are you taking birth control pills? Y N

Are you pregnant? Y N Not Sure

Are you nursing? Y N Week #: _____

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Are you taking any prescription medicines? Y N

Do you routinely take any over-the-counter medicines? Y N

List each prescription you take. If you take an over-the-counter medicine most days, list it as well:

_____

_____

_____

_____

_____

_____

_____

Have you ever been hospitalized for any reason? Y N

If yes, why? _____

_____

Hospitalized in the past 12 months? Y N

If yes, why?_____

_____

Do you or have you experienced the following?

Artificial (prosthetic heart valve)	Y	N	DK
Previous infective endocarditis	Y	N	DK
Damaged valves in transplanted heart	Y	N	DK

Congenital heart disease (CHD)

Unrepaired, cyanotic CHD	Y	N	DK
Repaired (completely) in last 6 months	Y	N	DK
Repaired CHD with residual defects	Y	N	DK

Cardiovascular disease	Y	N	DK
Angina	Y	N	DK
Arteriosclerosis	Y	N	DK
Congestive heart failure	Y	N	DK
Damaged heart valves	Y	N	DK
Heart attack	Y	N	DK
Heart murmur	Y	N	DK
Low blood pressure	Y	N	DK
High blood pressure	Y	N	DK
Other congenital heart defects	Y	N	DK
Mitral valve prolapse	Y	N	DK
Pacemaker	Y	N	DK
Rheumatic fever	Y	N	DK
Rheumatic heart disease	Y	N	DK
Abnormal bleeding	Y	N	DK
Anemia	Y	N	DK
Blood transfusion	Y	N	DK
If yes, date: _____			
Hemophilia	Y	N	DK
AIDS or HIV infection	Y	N	DK
Arthritis	Y	N	DK

Autoimmune disease	Y	N	DK
Rheumatoid arthritis	Y	N	DK
Systemic lupus	Y	N	DK
Asthma	Y	N	DK
Bronchitis	Y	N	DK
Emphysema	Y	N	DK
Sinus trouble	Y	N	DK
Tuberculosis	Y	N	DK
Cancer/Chemotherapy/ Radiation Treatment	Y	N	DK
Chest pain upon exertion	Y	N	DK
Chronic pain	Y	N	DK
Diabetes Type I or II	Y	N	DK
Eating Disorder	Y	N	DK
Malnutrition	Y	N	DK
Gastrointestinal disease	Y	N	DK
GE Reflux/persistent heartburn	Y	N	DK
Ulcers	Y	N	DK
Thyroid problems	Y	N	DK
Stroke	Y	N	DK
Glaucoma	Y	N	DK

Hepatitis, jaundice or liver disease	Y	N	DK
Epilepsy	Y	N	DK
Fainting spells or seizures	Y	N	DK
Neurological disorders	Y	N	DK
Specify: _____			
Sleep Disorder	Y	N	DK
Mental health disorders	Y	N	DK
Specify: _____			
Recurrent Infections	Y	N	DK
Specify:_____			
Kidney problems	Y	N	DK
Night sweats	Y	N	DK
Osteoporosis	Y	N	DK
Persistent swollen glands In neck	Y	N	DK
Severe or rapid weight loss	Y	N	DK
Sexually transmitted disease	Y	N	DK
Excessive urination	Y	N	DK
Sickle Cell Anemia	Y	N	DK

OTHER problem? Y N

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I certify that I have read and understand the above and that the information given on this form is accurate. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

X_____ Date _____

Signature of Patient/Legal Guardian

We are delighted to provide you and your family dental services at TenderCare Dental Clinic. At every visit, you will receive individualized attention for your specific medical and dental needs. You will have all of your questions and concerns addressed. You will receive care in a courteous and timely manner – we want this to be your best dental visit, *ever*! We require your compliance with our policies, because they enable us to provide our community with the highest quality of compassionate dental services.

This is a "SMOKE FREE" building. All smoking is prohibited. No alcohol or drug use is allowed on property, including the parking area. Law enforcement is available to escort any violator off the premises.

All co-pays, deductible amounts, and patient portions must be paid *at the time of service*.

If you are a Georgia Medicaid member, law requires that you present your current card *at each visit*.

If you have received a Reduced Fee/Slide Eligibility card, you must present your current card *at each visit*.

A government-issued photo ID and an in-person photo are required for accurate patient identification.

No Shows and Cancellations

This "No Show Policy" is also posted in the office; it follows a two-strikes rule. We must have your current contact information. We will call you 48 hours in advance of your appointment, and we must speak with you in-person to confirm your appointment time. If we have not heard from you 24 hours prior to your appointment, then it is cancelled. You may present as a "walk-in" for treatment as time permits. If you contact the office less than 24 hours before your appointment time to cancel or change it, then we do not have time to fill our schedule. If you are over 15 minutes late for your appointment time, your appointment is cancelled. If you "break" your appointment in any of these ways, you receive one strike. You will be informed if you receive a strike. After receiving two strikes, any future appointments are cancelled, and you may be given an appointment day. Present at 8:15AM for your appointment day and you will be treated on a "walk-in" basis as time permits. This policy guides the management of dental patients who do not keep appointments, or cancel with little notice, to maximize access for those patients responsible for keeping appointments.

Appointment Time is Doctor Time – Arrive Early

When confirming your appointment, we ask you to arrive 15 minutes prior to your appointment time. Your appointment time is your doctor time – please arrive early for check-in, insurance verification, and to be seated in the treatment room. If you arrive later than 15 minutes after your appointment time, you have two options: reschedule for another day, or wait to be treated on a "walk-in" basis as time allows.

Billing, Payment and Collections Policy

Payment is expected at the beginning of your appointment. You are informed of the approximate fees for your next visit in three instances: (1) when you contact the office to set up an appointment, (2) at the end of your previous appointment, and (3) when you are contacted to confirm your appointment. We accept payment in the form of cash, Visa, Mastercard, Discover or *local* check with a valid driver's license. If there are any changes in your treatment, we will

collect or credit your account at check-out. All returned checks are subject to a $25 service charge. If you are unable to pay your balance at the time of your appointment, we must reschedule your appointment. Statements are mailed monthly; please ensure your contact information is current for both phone and mail correspondence.

You must pay your balance before your next visit. Accounts over 90 days past due may be sent to a collections agency. You are responsible for collection fees, legal fees and additional costs associated with the delinquent account.

Dental Insurance Benefits

TenderCare Dental Clinic participates in Georgia Medicaid and PeachCare programs. Please present your current Medicaid or PeachCare card at check-in; law requires you bring your card to every appointment, or we must reschedule. We endeavor to participate with third-party insurers – please confirm "in-network" status with our front office and your insurance company before scheduling. We cannot guarantee insurance information given to us by insurance companies is correct or reflects current coverage. Your particular plan *may or may not* provide coverage for the services we advise are necessary for your health and well-being. If you are asked to return for a follow-up or next step appointment, you must do so *within one month*. This includes multistep procedures, such as crowns, dentures and bridges.

We accept assignment of your insurance benefits and file the claim with your insurance company as a courtesy to you. You are expected to pay your estimated portion at time of service. This is only an *ESTIMATE*. When your insurance company reimburses our claim, a balance may be due from you. Account statements are mailed monthly. We allow your insurance company 50 days to pay your claim. If your insurance does not pay, your account balance is your responsibility, and is subject to the above Billing, Payment and Collections Policy.

Reduced Fee Program

TenderCare Dental Clinic offers a reduced-fee program for patients who document their low-income status with the TenderCare Eligibility Coordinator. Once approved, you must bring your eligibility card with you to receive reduced fees for that visit. Meet with the Coordinator first – fees for services already rendered cannot be reduced.

Parents and Legal Guardians

Minors (under age 18) must be accompanied by a parent or legal guardian, with appropriate documentation of parental status and legal custody, as needed. A minor may be treated individually if he/she provides documentation of legal emancipation. The parent or legal guardian of a minor is expected to remain on the premises for the duration of the visit, as additional treatment consent or health information may be required.

Patient Escort Policy

We must limit the number of people in the dental room to maintain safe operatory conditions for effective management of medical emergencies, and to deliver quality dental services consistently. Patients with a significant disability, or who require language interpretation, may be accompanied by one person. Parents of minor children are welcome in the operatory after the procedure is complete to discuss all findings and recommendations. Parents have the opportunity to enumerate their pre-treatment concerns on check-in paperwork. A "parent chair" is available in the treatment area hallway for an individual parent who wants to be in "hearing range" of a child patient; no parents are allowed in the treatment room, except as specifically indicated above.