Adderley Dental Group

PATIENT REGISTRATION

Patient Information

First Name: ______________________________ Last Name: ______________________________ Middle Initial: ________

Patient Is: ☐ Policy Holder ☐ Responsible Party Sex: ☐ Male ☐ Female

Birth Date: ____________________ Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separate ☐ Widowed

Address: ________________________________ City :__________________________ State: _________ Zip: ____________

____

Home Phone: ______________________________ Work Phone: ____________________ Cell: ______________________

SSN: ________________________________ E-mail: ___________________________________

Emergency Contact Name: ________________________________ Number: __________________________ Relationship: ____________

How did you hear about Adderley Dental Group? ____

Responsible Party (If Someone other then Patient)

First Name: ____________________________ Last Name: ______________________________ Middle Initial: ________

Birth Date: __________________ Sex: ☐ Male ☐ Female

Address: ___________________________ City :__________________________ State: _________ Zip: ___________________

Home Phone: ______________________________ Work Phone: ____________________ Cell: ______________________

Soc. Sec: _________________________________ E-mail: _____________________________________

☐ Responsible party is also Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Primary Insurance Information

Name of Policy Holder: _____________________________ Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other

DOB of Policy Holder: ___________________________

Insurance Company: _____________________________

ID Number: _____________________________________

Group Number: __________________________________

Employer: ______________________________________

Secondary Insurance Information

Name of Policy Holder: _____________________________ Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other

DOB of Policy Holder: ___________________________

Insurance Company: _____________________________

ID Number: _____________________________________

Group Number: __________________________________

Employer: ______________________________________

Adderley Dental Group, PC

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.

Question	Answer	
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

For Women: Are you...

Pregnant? Yes / No — Trying to get pregnant? Yes / No — Nursing? Yes / No

Taking Birth Control Yes / No If yes

Are you alleric to any of the following?

- Asprin
- Penicillin
- Codeine
- Acrylic
- Metal
- Latex
- Sulfa Drugs
- Local Anesthetics

Other? ☐ If yes

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

Condition	Answer	Condition	Answer	Condition	Answer	Condition	Answer
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	Syncope	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:__________

NOTICE OF PRIVACY ACKNOWLEDGEMENT PRACTICES

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (**HIPPA**), that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at anytime at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also 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.

Patient Name: ____

Relationship to Patient: ______________________________________

Signature: ____

Date: ____

OFFICE USE ONLY

I attempted to obtain the patients signature in acknowledgement on this Notice of Privacy Practice Acknowledgement, but was unable to do so as documented below:

Date:	Initial:	Reason:

“Your Smile Matters”

Toni Adderley D.D.S

Adderley Dental Group

Financial Agreement and Office Policy

Please review the following carefully, then sign and date the bottom of this agreement once you have reviewed it and understand it fully.

Payment is due at the time dental treatment is performed.

♦ We accept Visa, MasterCard and American Express.

♦ If you have dental insurance, as a courtesy to you, we will submit your insurance claim electronically for processing. We will estimate your insurance carriers’ portion and the guarantors’ portion due by you at the time of service. Should your insurance carrier pay less than the estimated amount, you will be billed for that balance and it will be payable upon receipt.

♦ Financing options are available through Care Credit financing and must be secured in advance of treatment. Brochures and applications are available at the front desk. You can also apply for Care Credit online at carecredit.com. Please don’t hesitate to ask if you have questions or would like an application.

♦ Appointment Scheduling is a critical part of our day. With that in mind, we require at least two working days notice to cancel or move a scheduled appointment. We make every effort to provide appointment cards and reminder phone calls for our patients so that they are informed of the next appointment they have scheduled. Cancellations or missed appointments without the two working days notice will be charged a $25.00 appointment fee.

By signing this agreement you understand and agree to the policies of this office. Furthermore, you understand that we do our best to estimate treatment and its cost and that final treatment is determined upon the completion of dental work. Insurance benefits can only be ESTIMATED.
A written pre estimate/authorization of dental benefits from your insurance carrier is not a guarantee of payment. Please refer to your carrier handbook for specifics on benefit coverage for your plan. Costs not covered by your insurance carrier become the immediate responsibility of the guarantor.
Adderley Dental Group is NOT responsible for the collection of dental insurance benefits but that claims will be as a courtesy to the patient. We make every attempt to ensure the accuracy of your dental claim based on the information provided by each patient. It is the patients’ responsibility to update carrier information, as changes become necessary. You understand that all costs not paid by your insurance carrier are the responsibility of the guarantor and due within 30 days. If payment is not received within 60 days of date of service there will be a finance charge of 1.50% of current balance.

I agree to pay that finance charge. In the event that collection action becomes necessary, I further agree to pay ALL collection involved.

Signature: ___________________________________ Date: ______________

____
Print Name

NO SHOW/MISSED & LATE ARRIVAL APPOINTMENT POLICY

When we set up an appointment, a specific amount of time is reserved especially for you. Many offices double or even triple book appointment to prevent from being financially damaged as a result of a missed appointment. However, double booking appointments does not allow us to give the care and attention needed to provide excellent quality dentistry and for this reason we choose to not do it.

We, at Adderley Dental Group, understand that sometimes you need to cancel or reschedule your appointment and that there are emergencies. If you are unable to keep your appointment, please call us as soon as possible (with at least a 24-hour notice). You can cancel appointments by calling the following number: **202-722-1731.**

To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality care, it is very important for each scheduled patient to arrive to their appointment 15 minutes prior to the scheduled time. As a courtesy to you, an appointment reminder call/text is made/attempted one (1) business day and one (1) hour prior to your scheduled appointment. However, it is the responsibility of the patient to arrive for their appointment on time.

PLEASE REVIEW THE FOLLOWING POLICY:

1. Please cancel your appointment with at least a 24 hours' notice: There is a waiting list to see Dr. Adderley and whenever possible, we like to fill cancelled spaces to shorten the waiting period for our patients.
2. If less than a 24-hour cancellation is given this will be documented as a "No-Show" appointment.
3. If you do not present to the office for your appointment, this will be documented as a "No-Show" appointment.
4. After the first "No-Show/Missed" appointment, you will receive a phone call warning that you have broken our "No-Show" policy. A staff at Adderley Dental Group will assist you to reschedule this appointment if needed.
5. If you have 2 "No-Show/Missed" appointments within six months' time period, you will receive a warning letter from our office and will be assessed a $25.00 no show fee.
6. If you have 3 "No-Show/Missed" appointments within a one-year time, you will receive a second $25 no show fee assessment. Dismissal from the practice will be considered.
   ***You will be notified by letter if the dismissal was approved.**
7. **Late arrival:** When we reserve time for you, we require all of that time provide you with the best quality work possible. When you are late it decreases our ability to accomplish this. If you arrive more than 10 minutes late, your appointment may be rescheduled in order to meet the needs of those who are on time for their pre-reserved visit. If this happens it will be considered a missed appointment.

I have read and understand Adderley Dental Group's No Show/Missed & Late Appointment Policy and understand my responsibility to plan appointments accordingly and notify Adderley Dental Group appropriately if I have difficulty keeping my scheduled appointments.

______________________________ ____________ ____________

Patient Name Date of Birth Date

______________________________ ______________________

Patient Signature or Parent/Guardian if minor Relationship to Patient

Adderley Dental Group
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