Oral Surgery
& Dental Implant Center
Of Panama City

Eric R. Claussen, D.M.D., P.A.

PATIENT REGISTRATION

PATIENT INSURANCE INFORMATION

Welcome to our office. So that we may assist you in filing your health insurance forms, please provide us with the information requested below.

All information is kept confidential.

Patient's Name: ______________________________ Today's Date: ______________

Sex: ______ Age: ______ Birth Date: ________________ Soc. Sec. #: ________________

Address: ____

City: _________________________ State: _____________ Zip: ________________

Home Phone: ________________________ Work Phone: ________________________

Spouse's Name: ____

Responsible Party's Name: ____

Soc. Sec. #: _____________________ Relationship to Insured: ______________________

Address: ____

City: _________________________ State: _____________ Zip: ________________

Employer: _______________________ Occupation: ___________________________

Address: ____

City: _________________________ State: _____________ Zip: ________________

Name of Insurance Plan: ______________________ Group Number: __________________

Physician: _________________________ Referring Dentist: _______________________

Orthodontist: ____

Reason for Visit: ____

Family members who have been patients here: ___________________________________

____

____

PATIENT HEALTH HISTORY

1. Are you in good health? Y N
2. Has there been any change in your general health in the past year? Y N
3. Date of last physical exam: ________________________
4. Are you under a physician's care for a particular problem? Y N
5. Have you ever had any serious illnesses, operations or hospitalizations? If so, describe. Y N

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____
____

6. DO YOU HAVE OR HAVE YOU EVER HAD:
   - a. Rheumatic Fever or Rheumatic Heart Disease? Y N
   - b. Congenital Heart Disease? Y N
   - c. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker)? Y N
   - d. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of breath, Chest Pain, Severe Coughing)? Y N
   - e. Seizures, Epilepsy, Dizziness, Psychiatric Treatment, or other Nervous Disorder? Y N
   - f. Bleeding Disorder, Anemia, Blood Transfusion? Do you bruise easily? Y N
   - g. Liver Disease (Jaundice, Hepatitis)? Y N
   - h. Kidney Disease? Y N
   - i. Diabetes? Y N
   - j. Thyroid Disease (Goiter)? Y N
   - k. Arthritis? Y N
   - l. Stomach Ulcers or Colitis? Y N
   - m. Glaucoma? Y N
   - n. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)? Y N
   - o. Radiation (X-ray) treatment for Cancer? Y N
   - p. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grinding or clenching teeth? Y N
   - q. Sinus or Nasal problems? Y N
   - r. Any disease, drug or transplant operation that has depressed your immune system? Y N
   - s. HIV, AIDS? Y N

7. Are you taking any: Y N
   - a. Anticoagulants (Blood Thinners)? Y N
   - b. Steroids (Corisone, etc.) Y N
   - c. Aspirin or drugs such as Motrin, Aleve, Ibuprofen? Y N
   - d. Osteoporosis medications (Fosamax, Boniva, etc.)? Y N
   - e. List all medications you are currently taking:

   ____
   ____

   - f. List any Herbal or Holistic remedies, Vitamins or over-the-counter medications:

   ____

8. LIST ANY DRUG ALLERGIES:

____
____

Are you allergic to latex? Y N

9. Height: ________ Weight: ________ Age: _______
   Date of Birth: ________________________
10. Do you smoke or chew Tobacco? Y N
11. Is there any past history of Alcohol, or Chemical Dependency or an Emotional Disorder that may affect the care we provide you? Y N
12. Have you had any serious problems associated with any previous dental treatment? Y N
13. Have you or an immediate family member had any problem associated with IV anesthesia? Y N
14. Do you have any other disease, condition, or problem not listed above that you think the doctor should know about? Y N
15. Do you wish to talk to the doctor privately about anything? Y N
16. FEMALES ONLY:
   - a. Are you Pregnant, or is there any chance that you might be? Y N
   - b. Are you nursing? Y N
   - c. Antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible. I have had the opportunity to discuss my Health History with my doctor.

____

Date | Signature of Person Completing Health History | Doctor's Initials

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, ____, have received a copy of this office's Notice of Privacy Practices.

____

Please Print Name

____

Signature

____

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ○ Individual refused to sign
- ○ Communications barriers prohibited obtaining the acknowledgement
- ○ An emergency situation prevented us from obtaining acknowledgement
- ○ Other (Please specify)

____

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This form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).

AUTHORIZATION FOR SUBMISSION OF CLAIMS AND ASSIGNMENT OF BENEFITS

I authorize Eric R. Claussen to submit claims for payment of services to the dental care service plans or insurance companies named below, on my behalf and in my name, and assign to such provider the group insurance benefits otherwise payable to me, but not to exceed to provider's actual charges for the covered services. I understand that I am financially responsible for any charges not covered by the group insurance benefits.

____
(Name of insurance carrier)

____
(Name of patient)

____
(Signature of patient, parent or guardian)

____
(Date)

I authorize Eric R. Claussen to release to hospital or health care services plans, insurance companies, self-insurers, or their representatives, any and all information and records (including x-rays) about my dental history, or about services rendered or treatment given to me, that is needed to review, investigate or evaluate and claim for benefits.

If my coverage is under a group master agreement held by my employer, an associate, trust fund, union or similar entity this authorization also permits disclosure to them for purposes of utilization review or financial audit.

This authorization shall remain effective for up to five years from this date.

I know I have the right to receive a copy of this authorization if requested.

____
(Name of patient)

____
(Signature of patient, parent or guardian)

____
(Date)

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _______________________________________’s dental needs.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me to employ such assistance as required to provide proper care.

3. I agree to use the anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Patient’s Signature ____________________________________ Date _____________ Witness ________________

Parent/Responsible Party’s Signature ______________________________ Relationship to Patient _____________