Patient Registration

First Name: ______________________ Last Name: ______________________

Preferred Name: ______________________ Marital Status: ________________

Date of Birth: ___________________ Gender: ________

Address: ____

City:__________________ State:__________________ Zip code:____________

Responsible Party's Name (if different from above): ______________________

Email Address:____

Home Phone: _____________________ Cell Phone: _________________________

I give permission for Sunfish Dental to send text messages for me at the number listed above: Initial _________________

I give permission to Sunfish Dental to leave a detailed voicemail message for me at the numbers listed above: Initial _________________

Preferred Pharmacy: ____

Occupation: ____

How did you hear about us? __________________________

I give permission for Sunfish Dental to speak to the following people about treatment and financials on my account:

____

Dental Insurance Information: - (Please provide a copy of the card as well)

Policy Holder's Name_________________________________

DOB of Policy Holder: _______________________________

Relationship to Patient: ______________________________

Employer: ____

Group Number:______________________ Member ID or SSN: _________________________

Claims Address: ________________________________ Contact Phone #:_________________

Patient/Parent or Guardian Signature_____________________________________ Date:____________

MEDICAL HISTORY

Patient's Name:____DOB: ___________________________

○ Yes ○ No Do you see a physician on a regular basis?

○ Yes ○ No Have you ever been hospitalized or had a major operation? If yes, please explain: _____________

____

○ Yes ○ No Have you ever had a serious head or neck injury? If yes, please explain: _____________________

____

○ Yes ○ No Are you taking any medications, pills, or drugs? If yes, please list: __________________________

____

○ Yes ○ No Are you allergic to any of the following? If yes, please check all that apply:

○ Aspirin ○ Penicillin ○ Codeine ○ Local Anesthetics ○ Acrylic ○ Metal ○ Latex

○ Sulfa Drugs ○ Other:____

○ Yes ○ No In the unlikely event that a member of our staff is exposed to my blood or body fluids through a needle stick, skin cut, or splash to the eyes/mouth area, I agree to have my blood tested (free of charge) for blood borne diseases.

○ Yes ○ No Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates?

○ Yes ○ No Do you take, or have you taken, Phen-Fen or Redux?

○ Yes ○ No Are you on a special diet?

○ Yes ○ No Do you use tobacco products?

○ Yes ○ No Do you use controlled substances?

Women: Are you Pregnant? ○ Yes ○ No Nursing? ○ Yes ○ No Taking oral contraceptives? ○ Yes ○ No

Do you have, or have you had, any of the following? (Check all that apply)

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

Have you ever had any serious illness not listed above? Yes ○ No ○ If yes, please explain: _________________

____

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 as health problems I may have, or medications I am taking, can have important interrelationships with the dentistry I will receive.

It is my responsibility to inform the dental office of any changes in medical status

Signature of **PATIENT**, **PARENT**, or **GUARDIAN**:_________________________________Date: _____________

Records Release

Patient Name: ______________________________ DOB ________________

Please include the NAMES and BIRTHDATES of any family members you wish to include in this records release:

____

____

TRANSFER RECORDS TO Sunfish Dental. I authorize the following clinic to release my records, including all requested dental information, copies or photocopies of my dental record and radiographs, concerning treatment given to me at:

Dental Practice Name: ____

Phone Number: ____________________ Email: _________________________

Address: ____

Reason for Leaving: Moving
Insurance is out of network
Hours of Operation
Billing Problem
Other (Please specify):______________________________________

TRANSFER RECORDS FROM Sunfish Dental. I am requesting my records be sent to:

[NEW OFFICE] Dentist/Clinic Name: ____________________________

Phone Number: _____________________ Email: ____________________________

Address: ____

____
Signature of Patient or Parent/Guardian

_________________________ __________________
Relationship to Patient Date

Office Policies

Thank you for choosing Sunfish Dental to be your dental provider! Dr. Tripp and her team are committed to providing the highest quality of care and best service possible. In order for our office to maintain efficiency for you, our patient, please take a moment to read through our office policies.

Dental Benefits

Please be prepared to show a valid photo ID and your current dental benefit card at each visit to our office. Dental benefits are a contract between you, your employer (if applicable) and the insurance company. As a courtesy, we will file your dental benefits claim for you and assist you with determining benefit information. However, if you have any additional questions about coverage, please contact your insurance company or human resources department. Please remember that dental benefits are not designed to cover 100% of the cost of all types of dental treatment. Generally, the goal of most policies is to provide only basic care for specific dental services. The benefits that you receive have nothing to do with your needs or achieving a high quality, complete result. Many needed services may not be covered. Treatment recommended by our dental professionals is never based on what your dental benefits will pay, but on what our team feels is best for your overall dental health. **At the time of treatment, the patient/guarantor is responsible for the estimated portion that your benefit plan does not cover (also called "copay").** Please remember that you are ultimately responsible for all expenses incurred. We request that you read your policy so that you are fully aware of coverage and any limitations of the benefits provided. In the event that a credit occurs on your account, a refund will be issued in a timely manner. ________(initial)

Financial Considerations

Financial arrangements are required before beginning any treatment that is not covered 100% by dental benefits. Payment, including your copay, is due on **the date of service** unless another arrangement has been made. There is a 4% fee on all credit card transactions. We are happy to accept check and cash payments without additional fees. Also, a 1.8% MN Care tax on all services rendered, this was implemented by the state of Minnesota.

The following payment options available to you are:

- PAYMENT IN FULL: Payment is due at the time of the appointment.
- AUTO-PAY: For treatment exceeding $100.00, our office offers an auto-payment plan with a credit or debit card kept on file. 50% of the total cost of treatment is processed on the day that treatment begins, and a 25% monthly payment is processed until the account is paid in full.
- THIRD PARTY FINANCING: CARE CREDIT offers deferred interest for larger treatment plans. A minimum purchase is required, and subject to credit approval. For more information, visit: www.carecredit.com. ________(initial)

Referrals

If the treatment required to address your dental needs cannot be provided in our office due to a degree of specialization of treatment, a referral will be given to a provider who can provide the necessary care. It is the patient's responsibility to call and set up an appointment. Because the procedure will be carried out in another office, fees will vary from ours, and only the specialist's office can give you an accurate estimate of the cost.________(initial)

Scheduling
Due to the fact that we are reserving time on our schedule for your appointment, we ask that you contact us by phone with a minimum of two business days advanced notice for any appointments that you may need to cancel and/or change. We understand that conflicts arise; however, failing to attend your appointment or canceling without adequate notice may result in a $75 charge per hour scheduled. This courtesy on your part will make it possible for us to offer your appointment time to another patient who needs to see the dentist or clinical team. ________(initial)

Delinquent Accounts
I agree to pay fees and expenses incurred by Sunfish Dental/Nicole Tripp, DDS, PLLC to collect on this account. After 90 days, all accounts that are not paid in full may be sent to a third party collection agency and are subject to interest at 1.5% monthly/18% annually. I agree to pay fees and expenses incurred by Sunfish Dental/Nicole Tripp, DDS, PLLC to collect on this account. It is agreed and understood that if this obligation should become delinquent that I, the patient or guarantor party, agree to pay the collection costs and costs associated with placing my obligation to a collection agency and/or attorney for litigation. ________(initial)

HIPAA Acknowledgement
I understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. Your personal health information will not be shared. I acknowledge that I have been provided with and understand this facility's Notice of Privacy Practices which provides a complete description of the uses and disclosures of my health information. I understand that I have the right to review this facility's Notice of Privacy Practices prior to signing this acknowledgement; this facility reserves the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy of any revised notice to the address I've provided if requested. ________(initial)

Agreement to Arbitration
By signing this agreement, the patient agrees with the office of Sunfish Dental/Nicole Tripp, DDS, PLLC that any dispute relating to dental care services rendered for any conditions, including any services rendered prior to the date this agreement was signed, and any dispute arising out of the diagnosis, treatment, or care of the patient, shall be resolved by binding arbitration. The patient understands that the result of this arbitration agreement is that claims, including malpractice claims he/she may have against the doctor, cannot be brought as the lawsuit in court before a judge or jury, and agrees that all such claims will be resolved as described in this section. ________(initial)

Authorization and Release
I certify that I have read and understand the above information to the best of my knowledge. I authorize Sunfish Dental to release any information including the diagnosis and records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners where applicable. I authorize and request my insurance company to pay directly to the dental practice insurance benefits otherwise payable directly to me. I understand that my insurance carrier may pay less than the usual bill for the services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

____
Signature of Patient/Responsible Party

____ ____________________________________
Printed Name of Patient Date

(Over)