TIME 08:56 AM DATE 3/11/2016

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

We thank you.
Welcome!

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Robert W. Yaskin, D.M.D.

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

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.

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	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other?	☐	If yes
Do you use controlled substances?	◯ Yes ◯ No	If yes

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

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

Have you ever had any serious illness not listed ◯ 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:_____

Family Dentistry of Ocean City

421 15th Street

Ocean City NJ 08226

Welcome to the Practice, we would like to get to know you better.

We like our patients to feel like they are a part of our family. Please let us know a few things about you:

- How did you find our Practice?

- Hobbies?

- Sports?

- If you have been to a Dentist within the past year, please tell me the Name and Phone Number of that Dentist? Have you had any full mouth or panoramic x-rays done within the past 3-5 years?

- Likes of previous dentist?

- Dislikes of previous dentist?

- Do you leave Ocean City in the Winter (snowbirds)?

FAMILY DENTISTRY
OF OCEAN CITY
CARING FOR A LIFETIME OF SMILES

Dr. Robert W. Yaskin
421 15th Street
Ocean City, New Jersey 08226
(609) 399-7173

OFFICE POLICIES AND FINANCIAL AGREEMENT

We view our patient relationships with a deep sense of responsibility. A major part of that responsibility is to help out patients understand and plan for their oral health along with providing each patient the highest quality of dental care. The following is a statement of Dr. Yaskin Office Policies and Financial Agreement. We ask that you please read, agree to and sign the agreement before any treatment is rendered.

REGARDING INSURANCE

For decades dental insurance has been an integral part of oral health planning; however, in the past few years it has become more difficult for the dental practice to deal with insurance companies. We are a third party to the contract and the insurance companies are not obligated to share your confidential policy information with us or required to send payment to us.

There are constant changes being made by your employer and insurance carriers to your coverage, deductibles and annual maximum. These changes are not being shared with us. Therefore, it is impossible for to know exactly what your policy covers. _____ (Initial)

In order for us to maintain our high level of service to you the patient, we provide the courtesy of submitting the claim on your behalf and supporting you with the maximizing your benefits. However, we are unable to carry your insurance balance for longer than 60 days. Policy coverage, changes and follow-up on unpaid claims is your responsibility. Please be prepared to show your insurance card at the time of your visit. _____ (Initial)

PAYMENT OPTIONS

Your options include Cash, Check, MasterCard, Visa and Discover. We are pleased to offer you a choice of No Interest or Extended Payment Plans to qualified applicants through CareCredit, our financial partner. If you would like to make extended payments for services provided at our office, please ask Cherie for assistance in filling out an application form. _____ (Initial)

ADDITIONAL CHARGES

A fee of $35.00 will be charged on all returned checks. _____ (Initial)

DELINQUENT ACCOUNTS

After 90 days, all accounts that are not paid in full may be sent to a third party collection agency. Any accounts turned over to collections will be assessed a collection fee of 40%. _____ (Initial)

CANCELLATION POLICY

If you are unable to keep an appointment, we ask that you kindly provide us with a minimum of two-business days notice. All changes in your scheduled appointment **must** be handled during our regular business hours. This courtesy on your part will make it possible to give your appointment to another patient who needs to see the dentist or hygienist. _____ (Initial)

OFFICE HOURS

Tuesday	8:00 AM – 6:00 PM
Wednesday	8:00 AM – 1:00 PM
Friday	9:00 AM – 6:00 PM

I have read, understand and agree to the above Office Policies and Financial Agreement.

_____ _____

PATIENT SIGNATURE **DATE**

(Parent/Guarantor signature if Patient is a MINOR)

_____

CHILD'S NAME