



PATIENT REGISTRATION

Please take a few minutes to answer the following questions so we can better assist you with your health care needs.

PATIENT INFORMATION

Today's Date _____ Birthdate _____ Patient Social Security # _____
Patient Name _____
(Last Name) (First Name) (Initial)
Address _____
City _____ State _____ Zip _____
Occupation _____ Male Female Single Married Widowed Divorced Separated
Patient Home Phone _____ Patient Work Phone _____
Patient Cell Phone _____ Patient E-Mail _____
Employer _____ Employer Phone _____
Employer Address _____
In Case Of Emergency Contact:
Name _____ Relationship _____
Emergency Home Phone _____ Emergency Work Phone _____
Whom may we thank for referring you to us? _____

PRIMARY INSURANCE

Individual responsible for this account _____
(Last Name) (First Name) (Initial)
Relationship to Patient _____ Birth date _____ Soc. Sec # _____
Address _____ Home Phone _____
City _____ State _____ Zip _____
Responsible Party Employed By _____ Business Phone _____
Business Address _____ Occupation _____
Insurance Company _____
Insurance Company Address _____
Subscriber I.D. # _____ Group # _____

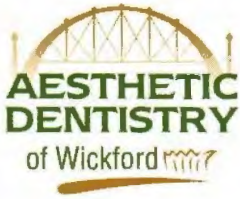
ADDITIONAL INSURANCE

Insured Individuals Name _____
(Last Name) (First Name) (Initial)
Relationship to Patient _____ Birth date _____ Soc. Sec # _____
Address _____ Home Phone _____
City _____ State _____ Zip _____
Insured Party Employed By _____ Business Phone _____
Insurance Company _____
Insurance Company Address _____
Subscriber I.D. # _____ Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, for any services provided me. I authorize any holder of medical and other information about me to release to Medicare and its agents, any insurance company, any other third party payer, state medical assistance agency, or any other governmental or private payer responsible for paying such benefits, any information needed to determine these benefits or benefits for related services. I agree to pay for all charges not covered by a third party payer. I authorize a copy of this authorization to be used in place of the original. In order to ensure proper follow-up and continuity of care, I agree that a copy of my medical record may be released to my physician, a designated referral physician, and/or the provider, if any, who referred me here. I expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered without obtaining my signature on each and every claim submitted.

Signature _____ Date _____



HEALTH HISTORY

MEDICATIONS

List medications you are currently taking

Pharmacy _____ Phone _____

ALLERGIES

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Penicillin
<input type="checkbox"/> Barbiturates	<input type="checkbox"/> Sulfa
<input type="checkbox"/> Codeine	<input type="checkbox"/> Other (please list)
<input type="checkbox"/> Iodine	_____
<input type="checkbox"/> Latex	_____
<input type="checkbox"/> Local Anesthetic	_____

CHECK ANY SYMPTOMS OR CONDITIONS BELOW YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST YEAR

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Depression/Nervousness | <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Poor Appetite |
| <input type="checkbox"/> Arm Pain or Numbness | <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Poor Circulation |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Double Vision | <input type="checkbox"/> Itching | <input type="checkbox"/> Prostate Problem |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Rapid Heartbeat |
| <input type="checkbox"/> Back Pain or Numbness | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Rash |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Lack of Bladder Control | <input type="checkbox"/> Rectal Bleeding |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Earache | <input type="checkbox"/> Leg Pain or Numbness | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Bloating | <input type="checkbox"/> Ear Discharge | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Ringing in Ears |
| <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Feet Pain or Numbness | <input type="checkbox"/> Loss of Hearing | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Fever | <input type="checkbox"/> Loss of Sleep | <input type="checkbox"/> Scars |
| <input type="checkbox"/> Bowel Changes | <input type="checkbox"/> Forgetfulness | <input type="checkbox"/> Loss of Weight | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Shoulders Pain or Numbness |
| <input type="checkbox"/> Brights Disease | <input type="checkbox"/> Gas | <input type="checkbox"/> Lumbago | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Measles | <input type="checkbox"/> Sore That Won't Heal |
| <input type="checkbox"/> Bursitis | <input type="checkbox"/> Hands Pain or Numbness | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Stomach Aches or Pains |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Headache | <input type="checkbox"/> Mumps | <input type="checkbox"/> Sweats |
| <input type="checkbox"/> Change in Moles | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Nausea | <input type="checkbox"/> Swelling Ankles |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Neck Pain or Numbness | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Neuralgia | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Herpes | <input type="checkbox"/> Neuritis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Chills | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Nose Bleeds | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Crossed Eyes | <input type="checkbox"/> Hips Pain or Numbness | <input type="checkbox"/> Painful Urination | <input type="checkbox"/> Vision Flashes |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Persistent Cough | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Hives | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Vomiting Blood |

Do you drink alcohol? If yes, how much / often? _____

Do you smoke and / or chew tobacco? If yes, how much / often? _____

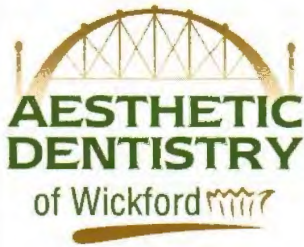
For women:

Are you pregnant? _____

Are you breastfeeding? _____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form

Signature _____ Date _____



Financial Policy

Thank you for choosing John W. Verbeyst, DMD and Philippe H. Morisseau, DMD, FAGD, AFAAID. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check, Visa, MasterCard, Discover, or American Express
- Convenient Monthly Payment Plans¹ from CareCredit
 - o Allow you to pay over time
 - o No annual fees or pre-payment penalties

Please note:

John W. Verbeyst, DMD and Philippe H. Morisseau, DMD, FAGD, AFAAID require payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

For plans requiring multiple appointments, alternative payment arrangements may be provided. For larger, more comprehensive treatment plans, a deposit is required to secure your initial treatment appointment.

For patients with Delta Dental, Blue Cross, and Cigna we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.² If you have a different insurance company from those listed, please ask a member of our team about submission and reimbursement of claims.

We kindly request a minimum of forty-eight hour notification when rescheduling an appointment. We do reserve the right to charge for missed appointments with less than forty-eight hour notification.

John W. Verbeyst, DMD and Philippe H. Morisseau, DMD, FAGD, AFAAID charge \$25 for returned checks. There is also a minimum late charge of \$25 per month if balances are not paid at the time of service unless other payment arrangements have been previously made.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

Patient, Parent or Guardian Signature

Date

Patient Name (Please Print)

¹Subject to credit approval

²However, if we do not receive payment from your insurance carrier within 90 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.