AESTHETIC DENTISTRY of Wickford

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 _____

POS Reorder # 1305737

AESTHETIC DENTISTRY of Wickford

HEALTH HISTORY

MEDICATIONS

List medications you are currently taking

_____

_____

_____

_____

Pharmacy_____ Phone _____

ALLERGIES

- ❒ Aspirin
- ❒ Barbiturates
- ❒ Codeine
- ❒ Iodine
- ❒ Latex
- ❒ Local Anesthetic
- ❒ Penicillin
- ❒ Sulfa
- ❒ Other (please list)

_____

_____

_____

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

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

AESTHETIC DENTISTRY of Wickford

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 Plans[1] from CareCredit
    - Allow you to pay over time
    - 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)

[1]Subject to credit approval

[2]However, 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.