PATIENT REGISTRATION

ID: ________ Chart ID: ________

First Name: ________ Last Name: ________ Middle Initial: ____

Patient Is: ☐ Policy Holder Preferred Name: ________

☐ Responsible Party

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

reduced fee sch: ________

Employer: ________

Emplyer Address: ________

Employer Phone #: ________

Primary Insurance Information

Name of Insured: ________ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: ________ Insured Birth Date: ________

Employer: ________

Address: ________

Address 2: ________

City,State,Zip: ________

Ins. Company: ________

Address: ________

Address 2: ________

City,State,Zip: ________

Rem. Benefits: .00 Rem. Deduct: .00

Secondary Insurance Information

Name of Insured: ________ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: ________ Insured Birth Date: ________

Employer: ________

Address: ________

Address 2: ________

City,State,Zip: ________

Ins. Company: ________

Address: ________

Address 2: ________

City,State,Zip: ________

Rem. Benefits: .00 Rem. Deduct: .00

MEDICAL HISTORY

PATIENT NAME ______________________________ Birth Date ______________________________

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, please explain: ______________________________
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: ______________________________
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: ______________________________
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: ______________________________
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? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics
☐ Other If yes, please explain: ______________________________

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

Condition		Condition		Condition		Condition	
AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No	Frequent Diarrhea	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No
Breathing Problem	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Genital Herpes	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	Heart Pace Maker	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No	Yellow Jaundice	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No		

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

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 ______________________________ DATE ______________

Byron L. Reintjes, D.D.S.
Financial Policy

Thank you for choosing us as your dental provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, which we request you read and sign prior to any treatment.

FULL PAYMENT IS DUE AT TIME OF SERVICE.

Please check preferred method of payment:
Cash_____ Check_____ Visa/Mastercard_____ Discover_____ American Express_____

Regarding Insurance
Under normal circumstances, we may bill and accept insurance payments upon verification of insurance. If insurance has not been verified we will require payment in full at the time of service. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event we do accept assignment of benefits we require that you pay the estimated co-payment for each visit at the time of service. If your insurance company has not made a claim payment in full within 45 days, the balance becomes your responsibility and is due in full. Any money paid by the insurance company after you have cleared your balance will be refunded to you. A service charge of 1½% per month (18% annum) will be charged on the unpaid balance on all accounts exceeding 60 days, unless previous written financial arrangements are established. Please be aware that some, and perhaps all, of the services provides may be non-covered services and not considered reasonable and necessary under your insurance. Any dental work deemed by your insurance coverage as optional or a non-covered benefit will be billed at the usual and customary rate.

Usual and Customary Rates
Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Missed Appointments
Unless canceled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. To avoid unnecessary cost to you please keep your appointments.

Overdue Accounts
You will be responsible for a $75.00 bookkeeping fee if your account is assigned to a third party for collections. Should suit be commenced to enforce any of the terms of this agreement, the prevailing party shall be entitled to reasonable attorney's fees and the Court of jurisdiction shall be in Fresno County. You hereby grant us or any assignee the right to verify employment or run a credit report to assess your ability to fulfill you financial obligation to this agreement.

In consideration of the professional services rendered to me, or at my request, by Dr. Reintjes and/or his staff, I agree to pay the reasonable charges for services provided. I give my permission for you to call me at home or work as needed to discuss and aspects of my treatment.

I have read, understand and agree to the Financial Policy above.

Sign____Date_________________________

FINANCIAL AGREEMENT

Your signature indicates that you have read, understand, and will abide by our FINANCIAL POLICY. I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor/child. **I accept full responsibility for all charges not covered by insurance.**

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have received and/or read a copy of Dr. Byron L. Reintjes NOTICE OF PRIVACY PRACTICES.

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance assign to Dr. Byron L. Reintjes, D.D.S. all benefits, if any, otherwise payable to me for service(s) rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the Doctor to release all information necessary to secure the payment of benefits. I hereby authorize the use of this signature on all my insurance submissions whether manual or electronic.

RELEASE OF EMAIL

I hereby release Dr. Byron Reintjes from any liability related to disclosure of confidential or privileged information. I hereby authorize the Doctor to release all information deemed necessary and acknowledge that Dr. Reintjes is taking all precautions to secure my information in compliance to the Notices of Privacy Practices by sending with every email attached with my patient information: The preceding e-mail message (including any attachments) contains information that may be confidential, be protected by the Doctor-Patient or other applicable privileges, or constitute non-public information. It is intended to be read only by the individual or entity to whom it is addressed or by their designee. You are informed that further use, dissemination, distribution, or reproduction of your email from our office is strictly prohibited and may be unlawful.

EDUCATIONAL CONSENT

I acknowledge that I am authorizing by signing A RELEASED INFORMED CONSENT OF MATERIAL INCLUDING, BUT NOT LIMITED TO PHOTOS, MODELS, AND TESTIMONIES HAVING TO DO WITH TREATMENT THAT DR. REINTJES HAS/WILL PERFORMED IN ORDER TO EDUCATE AND INFORM OF PROCEDURES AND PRACTICES PERFORMED BY BYRON L. REINTJES AND OR USE FOR AFTER INFORMED PURPOSES. ABSOLUTELY NO NAMES WILL BE ASSOCIATED WITH ANY DISCLOSURE EXCEPT WHERE AUTHORIZED, AS WELL AS POSSIBLE FUTURE PATIENTS upon Dr. Byron L. Reintjes discretion.

LOCAL ANESTHESIA CONSENT

I understand that my dental treatment may require the use of a local anesthetic for pain control. I understand that a local anesthetic may consist of different medications that are injected into the cheek or gum area. I understand that local anesthetics will cause a section of my mouth to become numb, which could last up to several hours. While the mouth is numb, caution must be used not to bite my lips or tongue.

I understand that if I have uncontrolled high blood pressure, uncontrolled thyroid problems, angina, or have recently has a heart attack, that I will inform Dr. Byron Reintjes immediately, as these conditions may cause complications while receiving local anesthesia.

I understand the recommendation of local anesthetic for my treatment, risks of treatment, any alternatives and risks of these alternatives, including consequences of not completing treatment.

I acknowledge that I have received and/or read a copy of Dr. Byron L. Reintjes INFORMED CONSENT OF LOCAL ANESTHESIA.

SIGNATURE:____________________________________ **DATE:**______________

PATIENT DEMOGRAPHICS			SCORING
LAST	FIRST	MIDDLE INITIAL	Neck Size +2 ≥ 16.5 (Male) +2 ≥15.0 (Female) ☐
DATE OF BIRTH	O MALE O FEMALE	ID#	
HEIGHT ____ FEET _____ INCHES	WEIGHT _____ POUNDS	NECK SIZE ____INCHES	

MEDICAL CONDITIONS: HAVE YOU BEEN DIAGNOSED OR TREATED FOR ANY OF THE FOLLOWING CONDITIONS?				
HIGH BLOOD PRESSURE	O Yes O No	STROKE	O Yes O No	+1 for each Yes response ☐
HEART DISEASE	O Yes O No	DEPRESSION	O Yes O No	
DIABETES	O Yes O No	SLEEP APNEA	O Yes O No	
LUNG DISEASE	O Yes O No	NASAL OXYGEN USE	O Yes O No	Do not assign any points for these eight responses
INSOMNIA	O Yes O No	RESTLESS LEG SYNDROME	O Yes O No	
NARCOLEPSY	O Yes O No	MORNING HEADACHES	O Yes O No	
SLEEP MEDICATION	O Yes O No	PAIN MEDICATIONS	O Yes O No	

EPWORTH SLEEPINESS SCALE: How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to mark the most appropriate box for each situation. (M.W. Johns, Sleep 1991)

0=would never doze 1=slight chance of dozing 2=moderate chance of dozing 3=high chance of dozing

Situation					Epworth Score
Sitting and reading	0	1	2	3	**TOTAL** the values from all 8 questions. If 11 or less **Score = 0** If 12 or more **Score = 2** ☐
Watching TV	0	1	2	3	
Sitting, Inactive, In a public place (theater, meeting, etc)	0	1	2	3	
As a passenger in a car for an hour without a break	0	1	2	3	
Lying down to rest in the afternoon when circumstances permit	0	1	2	3	
Sitting and talking to someone	0	1	2	3	
Sitting quietly after lunch without alcohol	0	1	2	3	
In a car, while stopped for a few minutes in traffic	0	1	2	3	

HABITS	Never	Rarely 0-1 times/wk	Sometimes 1-2 times/wk	Frequently 3-4 Times/wk	Always 5-7 times/wk	Habits Score
On Average in the past month, how often have you snored or been told that you snore?	O +0	O+1	O+2	O+3	O+4	**TOTAL** the values for all answers from first **3** habits questions ☐
Do you wake up choking or gasping?	O+0	O+1	O+2	O+3	O+4	
Have you ever been told that you stop breathing in your sleep or wake up choking or gasping?	O+0	O+1	O+2	O+3	O+4	
Do you have problems keeping your legs still at night or need to move them to feel comfortable?	O+0	O+0	O+0	O+0	O+0	

Would you be interested in participating in research? O Yes O No

The undersigned certifies that he/she is the patient or is duly authorized to complete and has completed this questionnaire.

Patient Signature________________________________ Date________________

Patient Phone Number________________________________

Physician Signature________________________________ Date________________

Physician (Printed)________________________________

Total all 4 boxes above.

Scoring chart
≤ = No Risk
4 or 5 Low Risk
6 to 10 = High Risk
≥ = Very High Risk
☐