

Registration and Treatment

Phone(H)

Phone (C)

Email:

Patient Information

Name

Date

Soc. Sec.#

Last Name

First Name

Middle Initial

Address

City

State

Zip

Sex

☐ M

☐ F

Age

Birthdate

☐ Single

☐ Married

☐ Divorced

☐ Separated

Patient Employed By

Occupation

Business Address

Business Phone

Whom May We Thank for Referring You?

In case of emergency who should be notified?

Phone

Primary Insurance

Person Responsible for Account

Relation to Patient

Birthdate

Soc. Sec. #

Address (if different from Patient's)

Phone

City

State

Zip

Person Responsible Employed By

Occupation

Business Address

Business Phone

Insurance Company

Group#

ID#

Plan Name

Names of other dependents under this plan

Additional Insurance

Is patient covered by an other plan? ☐ Yes ☐ No

Subscriber Name

Relation to Patient

Birthdate

Address (if different from patient's)

Phone

City

State

Zip

Subscriber Employed By

Business Phone

Insurance Company

Soc. Sec. #

Group#

ID#

Plan Name

Name of other dependents covered under this plan

Please complete above information and back of this page.....

Dental History													
Reason for Today's Visit													
Former Dentist													
Address													
Date of Last Dental Care	Date of Last Dental X-rays												
Check (✓) if you have had problems with any of the following: <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Bad breath</td> <td><input type="checkbox"/> Food collection between teeth</td> <td><input type="checkbox"/> Periodontal Tx</td> <td><input type="checkbox"/> Sensitivity to sweets</td> </tr> <tr> <td><input type="checkbox"/> Bleeding gums</td> <td><input type="checkbox"/> Grinding teeth</td> <td><input type="checkbox"/> Sensitivity to cold</td> <td><input type="checkbox"/> Sensitivity when biting</td> </tr> <tr> <td><input type="checkbox"/> Clicking or popping jaw</td> <td><input type="checkbox"/> Loose teeth/broken fillings</td> <td><input type="checkbox"/> Sensitivity to hot</td> <td><input type="checkbox"/> Sores or growth in the mouth</td> </tr> </table>		<input type="checkbox"/> Bad breath	<input type="checkbox"/> Food collection between teeth	<input type="checkbox"/> Periodontal Tx	<input type="checkbox"/> Sensitivity to sweets	<input type="checkbox"/> Bleeding gums	<input type="checkbox"/> Grinding teeth	<input type="checkbox"/> Sensitivity to cold	<input type="checkbox"/> Sensitivity when biting	<input type="checkbox"/> Clicking or popping jaw	<input type="checkbox"/> Loose teeth/broken fillings	<input type="checkbox"/> Sensitivity to hot	<input type="checkbox"/> Sores or growth in the mouth
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How Often Do You Floss?													

DO YOU NEED TO PREMEDICATE FOR DENTAL APPOINTMENTS? YES _____ NO _____

If you take premedication what medication and dosage is prescribed? _____

Who is the perscribing DR for the permedication? _____

Medical History	
Physician's Name & Date of Last Visit	
Have you had any serious illnesses or operations? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, describe	
Have you ever had a blood transfusion? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, give approximate dates	
(Women) Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No Nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No Taking birth control pills? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Check (✓) if you have or have had any of the following:	
<input type="checkbox"/> AIDS <input type="checkbox"/> Anemia <input type="checkbox"/> Arthritis, Rheumatism <input type="checkbox"/> Artificial Heart Valves <input type="checkbox"/> Artificial Joints <input type="checkbox"/> Asthma <input type="checkbox"/> Back Problems <input type="checkbox"/> Blood Disease <input type="checkbox"/> Cancer <input type="checkbox"/> Chemical Dependency <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Circulatory Problems	<input type="checkbox"/> Cortisone Treatments <input type="checkbox"/> Cough, Persistent <input type="checkbox"/> Cough up Blood <input type="checkbox"/> Diabetes <input type="checkbox"/> Epilepsy <input type="checkbox"/> Fainting <input type="checkbox"/> Glaucoma <input type="checkbox"/> Headaches <input type="checkbox"/> Heart Murmur <input type="checkbox"/> Heart Problems Describe <input type="checkbox"/> Hemophilia
<input type="checkbox"/> Hepatitis <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> HIV Positive <input type="checkbox"/> Jaw Pain <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Liver Disease <input type="checkbox"/> Mitral Valve Prolapse <input type="checkbox"/> Nervous Problems <input type="checkbox"/> Pacemaker <input type="checkbox"/> Psychiatric Care <input type="checkbox"/> Radiation Treatment <input type="checkbox"/> Respiratory Disease	<input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Scarlet Fever <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Skin Rash <input type="checkbox"/> Stroke <input type="checkbox"/> Swelling of Feet/Ankles <input type="checkbox"/> Thyroid Problems <input type="checkbox"/> Tobacco Habit <input type="checkbox"/> Tonsillitis <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Ulcer <input type="checkbox"/> Venereal disease
MEDICATIONS	ALLERGIES
Signature	Date

Allyn G. Perkins, DMD, LLC

1909 Ritner Highway, Suite 2

Carlisle, PA 17013

717-249-1646 Office

717-249-0951 Fax

Email: perkins1909@gmail.com

Website: www.carlisedentist.com

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1998 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

Obtain payment from third-party payers.

Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosure of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

If Responsible Party.....Relationship to Patient _____

Signature _____ Date ____/____/____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____

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OUR FINANCIAL POLICY

We are committed to providing you with the best possible care and would be happy to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your financial responsibility.

If you do not have insurance we expect payment in full for all treatment at the time of service, unless other arrangements have been made. We accept cash, checks, Visa and Master Card. We also offer interest free financing through Care Credit.

REGARDING INSURANCE

If you have insurance, we will help you receive maximum benefits. Your insurance claim will be completed and submitted if we are provided with all pertinent insurance plan information. It is your responsibility to verify that your policy is in force on your date of service and that you are eligible for the treatment proposed.

Insurance is an agreement between you and your insurance company. We submit claims as a courtesy to you, our patient. We will not become involved in disputes between you and your insurance company regarding deductible, co-payments, non-covered charges, secondary coverage, etc., other than to supply necessary factual information. Deductibles and co-payments are required at the time of service. You are responsible for the prompt payment of your account. If payment is not received from your insurance company within 90 days, the balance on the account becomes your responsibility.

AGREEMENT

I have read the above Financial Policy and understand that I am financially responsible for all charges whether or not paid by my insurance. I understand and agree that a monthly interest charge of 1.5% of my balance may be added to my account if my balance is not paid in full within 30 days. I understand and agree that my account may be turned over to a collection agency if not paid in full after the third billing and that a 25% collection fee will be added to my account.

Responsible Party Signature: _____ Date _____/_____/_____

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RELEASE OF DENTAL INFORMATION

AGREEMENT

Patient's Name: _____ Date of Birth: ____/____/____

Social Security Number ____-____-____

I authorize the office of Allyn G. Perkins, DMD to release information regarding my dental treatment / healthcare and financial information to:

Name: _____ Date of Birth ____/____/____

☐ Appointment info ☐ Financial info ☐ Treatment info ☐ All

Name: _____ Date of Birth ____/____/____

☐ Appointment info ☐ Financial info ☐ Treatment info ☐ All

Name: _____ Date of Birth ____/____/____

☐ Appointment info ☐ Financial info ☐ Treatment info ☐ All

Name: _____ Date of Birth ____/____/____

☐ Appointment info ☐ Financial info ☐ Treatment info ☐ All

Responsible Party Signature: _____ Date ____/____/____

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APPOINTMENT POLICIES

ANY PATIENT UNDER THE AGE OF 18 MUST HAVE A LEGAL GUARDIAN PRESENT WITH THEM AT ALL APPOINTMENTS

We hope to establish a long term relationship with you and look forward to providing you with optimal care at each and every visit.

A "broken" or "failed" appointment is any appointment not cancelled with AT LEAST 24 hours notice. Broken appointments prevent us from seeing another patient in the time that was reserved for you.

1. After your first "failed" appointment, you will be reminded of our policy by telephone. We realize people get sick, people sometimes forget, or an emergency arises. As soon as you know you cannot make the appointment, please call us.
2. After your second "failed" appointment we will mail you a copy of our appointment policy as a reminder and you will be charged a broken appointment fee of \$35. We also reserve the right to limit scheduling times and the number of family members scheduled at the same time.
 - a. **Please note that insurance companies **WILL NOT** pay broken appointment fees.
 - b. **These fees will have to be paid prior to any further appointment scheduling.
3. After your third "failed" appointment you will be dismissed from the practice. Should that occur, we will provide you with emergency care for up to 30 days and forward any necessary records to your new dental provider.

We make every effort to schedule you at a time that is most convenient while allowing adequate time for your necessary services. This time is reserved just for you. Please extend to us, and the other patients, the courtesy of keeping your appointments or, if necessary to reschedule, allowing adequate notice.

I have read, understand, and agree to the above Appointment Policies.

Responsible Party Signature _____ Date _____/_____/_____

Allyn G. Perkins D.M.D. LLC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-717-249-1646 (TTY: 1-717-249-1646).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-717-249-1646 (TTY : 1-717-249-1646)。