RUSSELL W. PHILLIPS, D.M.D.

ADVANCED RESTORATIVE DENTISTRY IMPLANTS AND COSMETICS

1625 K Street NW Suite Lower Level-1
Washington, DC 20006
P 202.463.2090 • F 202.463.7868 •
E mydentist@russellphillipsdmd.com

PATIENT REGISTRATION FORM

Please fax the completed form to (202) 463-7868 or bring in the completed form with you on your first appointment. Faxing the completed form ahead of time, will save you time during your visit and help us to be prepared for your appointment. Feel free to contact us at (202) 463-2090 should you have any questions. All patient information is confidential.

Date: ______________________________

PATIENT INFORMATION

Last Name: ________________________ First Name: ________________________ MI: ______

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

Address, City, State, Zip: ____

Home Phone: (   )__________ Work Phone: (   )__________ Cell Phone: (   )__________

Birth Date: __________ Social Security #: ____________ E-mail address: ________________

What is the best number to reach you during normal business hours? Cell Office Home E-mail

Employment: Full Time Part Time Retired

Employer Name: ____

Employer Address: ____

Student: Full Time Part Time Name of School Attending: ______________________________

Who referred you to our practice: ________________________________?

RESPONSIBLE PARTY

Last Name: ________________________ First Name: ________________________ MI: ______

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

Address, City, State, Zip: ____

Home Phone: (   )__________ Work Phone: (   )__________ Cell Phone: (   )__________

Birth Date: __________ Social Security #: ____________ E-mail address: ________________

PRIMARY DENTAL INSURANCE INFORMATION

Name of Insured: ________________________ Relationship of Patient: Self Spouse Child Other

Insured's Birth Date: ______________ Insured's SS#: ______________

Insured's Employer Name: ____
(If different from above)

Insurance Plan Name and Address: ____

ID #: ______________ Group #:______________ Insurance Phone #: ______________

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CONSENT FOR SERVICES

I have provided as accurate and complete a medical and personal history as possible including antibiotics, drugs, or other medications I am currently taking as well as those to which I am allergic. I will follow any and all treatment and post-treatment instructions as explained and directed to me and will permit the recommended diagnostic procedure, including x-rays.

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

____ Date: ____________ Relationship to Patient: ________
Signature of patient, parent or guardian

____ Date: ____________ Relationship to Patient: _________
Signature of guarantor of payment/responsible party

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HEALTH INFORMATION

Last Name: ______________________________ First Name: __________________________ Middle Initial: _____

Name of Physician: ____ Phone: _________________________

Emergency Contact: ____ Relationship: ______________________

Home Phone: __________________ Work Phone: __________________ Cell: ________________________

Have you ever had any of the following? ( ) Please check those that apply:

AIDS/HIV+	Dizziness	Liver Disease	Smoke or use Tobacco
Allergies, Kind: ____	Epilepsy	Metal/Jewelry reactions	Snoring
Anemia	Hay Fever	Mitral Valve Prolapse	Stroke
Arthritis, Rheumatism	Heart Attack	Nervous Problems	Thyroid Disease
Artificial Heart Valves	Heart Murmur	Osteoporosis	Tonsillitis
Artificial Joints	Hepatitis, Type: ____	Pacemaker	Tuberculosis (TB)
Asthma	Herpes	Psychiatric Care/Treatment	Ulcer/Colitis
Blood Disease	High Blood Pressure	Radiation Treatment	Venereal Disease
Cancer __________	Jaundice	Respiratory Problems	Are you pregnant?
Chemotherapy	Kidney Disease	Rheumatic Fever	Other: ____________
Diabetes: Type _____	Latex Allergies	Sleep Apnea	____________________

- Are you allergic to any of the following drugs? Aspirin Codeine Dental Anesthetics Erythromycin Penicillin Tetracycline Other ____________________
- Have you taken oral Bisphosphonates? Which kind: Fosamax (alendronate) Actonel (risedronate) Aredia Boniva Zometa Neridronate Olpadronate Other ____________________
- Do you need antibiotic premedication before dental treatment? Yes No
- Please list any and all medications you are taking including homeopathic, herbal and vitamin supplements.

  ____

- Have you been admitted to a hospital or needed emergency care during the past two years? Yes No

  If yes, please explain: ____

- Do you have any health problems that need further clarification? Yes No

  If yes, please explain: ____

- Have you ever had any complications following dental treatment? Yes No

  If yes, please explain: ____

- Have you or a family member been diagnosed with a sleep disorder? Yes No

  If yes, please explain: ____

____ Date: ______________ Relationship to Patient: ______________
Signature of patient, parent or guardian

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OFFICE FINANCIAL POLICIES

We thank you for choosing our dental practice. We are committed to providing you with the best possible dental care. In order to continue to do this, we need your understanding of, and adherence to, our office financial policies.

<u>Payment is due at the time services are rendered</u>. If you have dental insurance, we will gladly process your claims provided that you give us accurate insurance information and inform us of any changes in your insurance coverage prior to treatment.

Your insurance is a contract between you (or your employer) and the insurance company. We are not a party to that contract. Please be aware that some, or perhaps all, of the services provided may not be covered, may not be covered at 100% or may be considered at an alternate benefit rate under the policy your employer has selected for you. If a service is not covered, the fee becomes your responsibility. Any claim unpaid within 60 days of the date of service also becomes your responsibility.

We have a relationship with Care Credit and Chase a Manhattan to provide interest-free financing for up to 12 months or financing for up to 60 months at competitive interest rates (based upon approval of your application).

In the unlikely event that your account is placed in the hands of an attorney for collection, you agree to pay attorney fees of 33 1/3% of the unpaid balance plus court costs.

Your appointment time is reserved especially for you. Please help us serve you and our other patients better by keeping all scheduled appointments and arriving on time. Appointments that are missed or changed at the last minute are then not available to others who may need them. We reserve the right to charge a $150.00 fee for missed hour appointment without at least 48 hour's notice. Please consider your schedule carefully when scheduling your appointments.

Thank you for taking time to read and understand our office financial policies. Please let us know if you have any questions regarding your treatment or your financial responsibilities. We will be glad to review them with you at any time.

I have read, understand and agree to the policies set forth by the practice.

_______________________________________ Name

_________________________________ Date

_______________________________________ Signature

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ACKNOWLEDGEMENT OF PRIVACY PRACTICES

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- ❑ Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- ❑ Obtain payment from third-party payers for my health care services
- ❑ Conduct normal health care operations such as quality assessment and improvement activities
- ❑ Please indicate which person or persons you wish not to be contacted.

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office 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 and I understand that 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: ____ Date: _____________________________

Signature: ____

Relationship to Patient: ______________________________

Dependent family members also covered by this acknowledgement:

____

- -

For Office Use Only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

The patient refused to sign

Communication barriers

Emergency situation

Other