Chart# _____

REGISTRATION FORM

Section I **Patient Information** **Date**_____

Name:_____ I Prefer to be called: _____

Address:_____City:_____State:_____Zip:_____

Phone (____) _____ Work Phone (____) _____ Cell Phone (____) _____

The best time to contact me is:_____ ☐ A.M. ☐ P.M. On my ☐ Home phone ☐ Work phone ☐ Cell phone

Date of Birth:_____ Social Security Number:_____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Spouse or Parent's Name:_____

Whom may we thank for referring you? _____

Person to contact in case of emergency:_____ Phone_____

Email Address_____

HEALTH INFORMATION

Date of Last Dental Visit: _____**Reason for this visit:** _____

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

O HIV/AIDS
O Allergies_____
_____
O Anemia
O Arthritis
O Artificial Joints
O Asthma
O Blood Disease
O Cancer
O Diabetes-Type_____
O Dizziness
O Epilepsy
O Do You Smoke Cigarettes?
O Yes O No

O Excessive Bleeding
O Fainting
O Glaucoma
O Growths
O Hay Fever
O Head Injuries
O Heart Disease
O Heart Murmur
O Hepatitis-Type_____
O High Blood Pressure
O Jaundice
O Kidney Disease

O Liver Disease
O Mental Disorders
O Nervous Disorders
O Pacemaker
O Pregnancy
Due Date: _____
O Radiation Treatment
O Respiratory Problems
O Rheumatic Fever
O Rheumatism
O Sinus Problems
O Stomach Problems

O Stroke
O Tuberculosis
O Tumors
O Ulcers
O Venereal Disease
O Codeine Allergy
O Penicillin Allergy
O OTHER:
_____

- Have you ever had any complications following dental treatment? O Yes O No
  If yes, please explain _____
- Have you been admitted to a hospital or needed emergency care during the past two years? O Yes O No
  If yes, please explain _____
- Are you now under the care of a physician? O Yes O No
  If yes, please explain _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? O Yes O No
  If yes, please explain _____

To the best of my knowledge, all the information provided is true and correct. If I ever have any change in my health. I will inform the doctors at the next appointment without fail.

Signature _____**Date** _____

Section II — Responsible Party

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other
Name:_____ Relationship to Patient: _____
Address:_____
City:_____ State:_____ Zip:_____ Phone: (_____)_____
Employer:_____ Work Phone (_____)_____SSN#_____

Employment Information

Employer Name: _____ **Phone:** _____
Address: _____
City: _____ **State:** _____ **Zip Code** _____

Section III — Insurance Information

Name of Insured_____DOB_____Relationship to Patient _____
SSN#:_____ Name of Employer: _____ Work Phone: (____) _____
Address of Employer:_____City_____State:_____Zip _____
Insurance Company_____ Grou[p #_____ ID#_____
---------- DO YOU HAVE ANY ADDIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING ----------

Name of Insured_____DOB_____Relationship to Patient _____
SSN#:_____ Name of Employer:_____ Work Phone: (____)_____
Address of Employer:_____City_____State:_____Zip _____
Insurance Company_____ Grp #_____ ID#_____

Consent for Services

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 cost 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 service 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 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 services charge of 1 ½% per month, 18% annually will be charge on all accounts exceeding 60 days, unless previously written financial arrangements are made.
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 by the Doctor, or his assignee at the time said services are rendered, or within five days of billing if credit shall 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 billed to me, unless other arrangements had been made by me and the Doctor. 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 permission to you or your assignee to telephone me at home or at work to discuss matters related to this form. I have read the above conditions or treatment and payment and agree to their content.

Signature _____ **Date** _____

U. Phillip Igbinadolor, D.M.D., & Associates, P.A.
2416 West Sugar Creek Rd.
Charlotte, NC 28262
Tel. (704) 494-8484
Fax (704) 494-8483

STATE FUNDED PATIENT

FACTS OF LIFE ABOUT STATE FUNDED PROGRAMS:

1. For every single service we provide for state funded patients, we receive only a portion of our private practice fees. It is illegal in North Carolina to charge the patient the difference between the amount the state will pay and our usual customary fee.
2. There is a constant ongoing problem with claims submitted to our state for payments. We must remain current on all charges in state policy, and it seems the policy changes with every bulletin.
3. After doing a survey and keeping very accurate records, we know that over one-half of our state funded patients fail to keep their scheduled appointments.

Because of these above facts, our office has established the following rules:

- The patient must be cooperative in the scheduling of appoitments.
- The patient must keep scheduled appointments. If the need of cancelling an appointment arises, please give 24-hour notice.
- If the patient failed to come to a number of appointments (three or more) without notice, the patient will be release from the practice.
- The patient must present a valid MEDICAID of HEALTH CHOICE card at each visit, in addition to one form of identification; for example, driver's license, or we will not be able to see the patient.
- The patient must be on time.

We appreciate the opportunity of working with you in addressing your dental needs. Your understanding and knowledge of our office policies will greatly facilitate our efforts.

Thank you for your cooperation

Signature: _____ **Date:** _____

U. Phillip Igbinadolor, D.M.D., & Associates, P.A.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgment

I,_____, have received a copy of this offices' Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtain because

- o Individual refused to sign
- o Communication barriers prohibited obtaining the acknowledgement
- o An emergency situation prevented us from obtaining acknowledgement
- o Other (Please Specify) _____