

# DR. ANUSHKA AMIN AND DR. DANIEL HODGES REGISTRATION FORM

(Please Print)

Today's date:				Confirmation Method (circle): TEXT   EMAIL   PHONE				
PATIENT INFORMATION								
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid		
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No		If not, what is your legal name?		Email Address:		Birth date: / /	Age: 	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Social Security #:		Home phone #: (   )			
City:		State:	ZIP Code:	Mobile phone #:		Cell Provider:		
Occupation:		Employer:			Employer phone #: (   )			
Chose office because/Referred to office by (please check):				<input type="checkbox"/> Dr. _____		<input type="checkbox"/> Location <input type="checkbox"/> Friend		
<input type="checkbox"/> Family		<input type="checkbox"/> Online		<input type="checkbox"/> Other				
Other family members seen here:								

INSURANCE INFORMATION							
(Please give your insurance card to the receptionist.)							
Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: (   )				
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Occupation:	Employer:		Employer phone #: (   )				
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Please indicate primary insurance		<input type="checkbox"/> Delta Dental	<input type="checkbox"/> Cigna	<input type="checkbox"/> Metlife	<input type="checkbox"/> Aetna	<input type="checkbox"/> Blue Cross Blue Shield	
<input type="checkbox"/> Ameritus		<input type="checkbox"/> United Concordia	<input type="checkbox"/> Guardian	<input type="checkbox"/> Self-pay	<input type="checkbox"/> other		
Subscriber's name:	Subscriber's S.S. #:	Birth date: / /	Group #:	Policy #:			
Patient's relationship to subscriber:				<input type="checkbox"/> Self		<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone #.: (   )	Mobile phone #.: (   )
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Dr. Anushka Amin or insurance company to release any information required to process my claims.			
_____ <i>Patient/Guardian signature</i>		_____ <i>Date</i>	

Continue →

# Dental and Medical History

Please fill this form out entirely. This information is important to your dental care!

## MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?  
(Please check any that apply)

- Cancer or tumor
- Heart ailment or angina
- Heart murmur, mitral valve prolapse, heart defect
- Rheumatic fever or rheumatic heart disease
- Artificial joint or valve
- High or low blood pressure
- Pacemaker
- Tuberculosis or other lung problems
- Kidney disease
- Hepatitis or other liver disease
- Alcoholism
- Blood transfusion
- Diabetes
- Neurologic condition
- Epilepsy, seizures, or fainting spells
- Emotional condition
- Arthritis
- Herpes or cold sores
- AIDS or HIV positive
- Migraine headaches or frequent headaches
- Anemia or blood disorders
- Abnormal bleeding after extractions, surgery, or trauma
- Hayfever or sinus trouble
- Allergies or hives
- Asthma

Do you smoke or use chewing tobacco?  yes  no

Are you allergic to, or have you reacted adversely to any of the following?

- Latex materials
- Penicillin or other antibiotics
- Local anesthetics ("Novocain")
- Codeine or other narcotics
- Sulfa drugs
- Barbiturates, sedatives, or sleeping pills
- Aspirin
- Other: \_\_\_\_\_

Are you taking any of the following?

- Aspirin
- Anticoagulants (blood thinners)
- Antibiotics or sulfa drugs
- High blood pressure medicine
- Antidepressants or tranquilizers
- Insulin, Orinase, or other diabetes drug
- Nitroglycerin
- Cortisone or other steroids
- Osteoporosis (bone density) medicine
- Other: \_\_\_\_\_

Women:

- May be pregnant  
Expected delivery date: \_\_\_\_\_
- Taking hormones or contraceptives

Name of your physician: \_\_\_\_\_

Do you have any disease, condition, or problem not listed above? \_\_\_\_\_

When was your last dental visit? \_\_\_\_\_ What was done? \_\_\_\_\_

What is the name of your last dentist? \_\_\_\_\_ If none please initial: \_\_\_\_\_

Have you had any unfavorable reactions from dental treatments? \_\_\_\_\_ If yes, please explain. \_\_\_\_\_

What is the reason for your visit today? \_\_\_\_\_

Please add anything else you would like us to know about: \_\_\_\_\_

Signature of patient (or parent) \_\_\_\_\_ Date \_\_\_\_\_

# Credit Policy

In the interest of good health care practice, it is best to establish a policy to avoid misunderstandings. Our primary responsibility is to help our patients experience good health and we wish to spend our time and energy toward that end. Therefore, we wish to clarify the following points:

1. All accounts are due and payable at the time of your visit unless satisfactory arrangements have been made with our office manager.
2. We cannot accept responsibility for collecting an insurance claim or for negotiating a disputed claim. Insurance reimbursement is a contract between you and your carrier. If payment is not received from your insurance company within 60 days from the date of the claim, you are responsible for payment of your account.
3. It is not our intention to cause you undue hardship, however, we must continue our service to the community.

I have read this Credit Policy and understand that, regardless of any insurance coverage I may have, I am responsible for payment of my account within the usual limits of the Credit Policy (60 days). I agree that in the event costs and/or fees are incurred in connection with the collection of my account, I will pay all such costs and fees. This includes but is not limited to, collection costs, attorney's fees, and all court costs.

Date: \_\_\_\_\_

X

\_\_\_\_\_  
Party responsible for the account

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## HIPPA Acknowledgement

\*You may refuse to sign this acknowledgement\*

I, \_\_\_\_\_, have read a copy of this office's notice of Privacy Practices.  
Please Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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For office use only:

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

- Individual refused to sign.
- Communication barriers prohibited us from obtaining the acknowledgment.
- An emergency prevented us from obtaining acknowledgment.
- Other (please specify): \_\_\_\_\_