

PATIENT REGISTRATION

ID: _____ Chart ID: _____

First Name: _____ Last Name: _____ Middle Initial: _____

Patient Is: Policy Holder Responsible Party Preferred Name: _____

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 **text**.

<p>Section 2</p> <p>Employment Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired</p> <p>Student Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time</p> <p>Medicaid ID: _____ Pref. Dentist: _____</p> <p>Employer ID: _____ Pref. Pharmacy: _____</p> <p>Carrier ID: _____ Pref. Hyg: _____</p>	<p>Section 3</p> <p>Emergency Contact</p> <p>B. Mother's name</p> <p>C. Father's Name</p> <p>D. Mom's cell phone</p> <p>E. Dad's cell phone</p> <p>F. Grandma's #</p> <p>G. _____</p>
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Primary Insurance Information

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____	Ins. Company: _____
Address: _____	Address: _____
Address 2: _____	Address 2: _____
City, State, Zip: _____	City, State, Zip: _____
Rem. Benefits: _____	Rem. Deduct: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____	Ins. Company: _____
Address: _____	Address: _____
Address 2: _____	Address 2: _____
City, State, Zip: _____	City, State, Zip: _____
Rem. Benefits: _____	Rem. Deduct: _____

Daniel B. Nigus, DDS., PC

2618 N. Belt Highway

St. Joseph, MO 64506

Consent for USE and Disclosure of Health Information

Patient Giving Consent

Name: _____ Social Security # _____

Address _____

Telephone: _____ Email: _____

To the Patient- PLEASE READ THE FOLLOWING STATEMENTS

Purpose of consents: By signing this form, you will consent to our use and disclosure of your protected health information (PHI) to carry out treatment, payment and healthcare operations.

Notice of Privacy Promotions: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses of disclosures we may make of your PHI and of the other important matters about your PHI. A copy of our notice accompanies this content. We encourage you to read it carefully and completely before signing this content. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised notice, which will contain the changes. Those changes may apply to any of your PHI that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our policies at any time by contacting: Daniel B. Nigus, DDS, Phone: 816-364-6467 Fax: 816-232-1645. E-mail: nigusdds@live.com

Right to revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation and that we may decline to treat you or to continue treating you if you revoke this consent.

SIGNATURE: _____ HAVE HAD FULL OPPORTUNITY TO READ AND CONSIDER THE CONTENTS OF THIS CONSENT FORM AND YOUR NOTICE OF PRIVACY PRACTICES. I understand that by signing this consent form, I am giving my consent to your use and disclosure of any PHI to carry out treatment, payment and health care operations.

SIGNATURE: _____ DATE: _____

IF THIS CONSENT IS SIGNED BY A PERSONAL REPRESENTATIVE ON BEHALF OF THE PATIENT, COMPLETE THE FOLLOWING:
PERSONAL REPRESENTATIVES NAME _____ RELATIONSHIP _____

YOU ARE INTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT

Eaglesoft Medical History(Copy)(Copy)

Patient Name:

Birth Date:

Date Created:

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, c

Are you under a physician's care now? Yes No If yes _____

Have you ever been hospitalized or had a major operation? Yes No If yes _____

Have you ever had a serious head or neck injury? Yes No If yes _____

Are you taking any medications, pills, or drugs? Yes No If yes _____

Do you take, or have you taken, Phen-Fen or Redux? Yes No If yes _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No If yes _____

Are you on a special diet? Yes No

Do you use tobacco? Yes No

Women: Are you...

Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic

Metal Latex Sulfa Drugs Local Anesthetics

Do you use controlled substances? Yes No If yes _____

Other? If yes _____

Have you ever had any serious illness not listed above? Yes No If yes _____

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

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

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:

X

Date: _____

DENTAL HISTORY

Purpose of this visit? _____

Previous Dentis: _____

Date of Last Pano _____

or complete series of x-rays? _____

Are you having discomfort at this time: Yes or No please circle. If yes, Please explain: _____

Do you feel nervous about dental treatment? Yes or No, please circle.

Have you ever had an upsetting experience in a dental office? Yes or No, please circle.

Are you subject to prolonged bleeding? Yes or NO, please circle.

Is it important to you to keep your teeth? Yes or NO, please circle.

Are you satisfied with the appearance of your teeth? Yes or NO, please circle. If No, please indicate how we can help you achieve your desires?

Additional remarks: _____

Acknowledgment and Authority:

I consent to treatment as necessary or desirable for the care of this patient first names, including, but not restricted to, whatever drugs, medicine, performance of operations and conduct of laboratory, x-rays or other studies that may be used the attending doctor, his assistant or qualified designate. I also acknowledge full responsibility for the payment of such services and agree to pay for them IN FULL AT THE TIME OF SERVICE, unless other arrangements are made in advance.

SIGNATURE (OR GUARDIAN) _____ DATE: _____

Daniel B. Nigus, DDS, PC

2618 N. Belt Highway St. Joseph, MO 64506

Written Financial Policy

Thank you for choosing Daniel B. Nigus, DDS, PC. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients by offering several payment options.

PAYMENT OPTIONS:

You can choose from: Cash, check, Visa, Mastercard, Discover and American Express.

Interest deferred payment plans through Care Credit.

1. Allows you to pay over a period of time with INTEREST DEFERRED PAYMENTS, if paid within the promotional period otherwise, assessed from purchase date. Minimum monthly payment is required.
2. Convenient, low monthly payment plans also available, with approved credit.
3. No annual fees or pre payment penalties.

Please note:

Daniel B. Nigus, DDS, PC require payment PRIOR to the beginning of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

For plans requiring multiple appointments, alternative payment arrangements may be provided.

For patients with dental insurance, we are happy to work with your insurance carrier to maximize your benefit and directly bill them for reimbursement for your treatment. **However**, if we don't receive payment from your insurance within 7 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

A fee of \$25 is charged for patients who MISS or CANCEL MORE THAN 1 TIME IN A CALENDAR YEAR WITHOUT A 24 HOUR NOTICIE.

DANIEL B. NIGUS, DDS, PC CHARGES \$25 FOR RETURNED CHECKS.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

X

Date: _____

Parent, Patient or Guardian Signature

X

Patient Name (PLEASE PRINT)

Daniel B. Nigus, DDS., PC

2618 N. Belt Highway

St. Joseph, MO 64506

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*****You May Refuse to Sign This*****

I _____ have received a copy of this office's 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 obtained because:

***Individual refused to sign**

***Communication barrier to sign**

***An emergency situation prevented us from obtaining acknowledgement**

***Other: Please specify:**
