EAGLESOFT ID NUMBER____________

REGISTRATION

PART 1: *PATIENT* INFORMATION

Today's Date:_____________ Full Name:_______________________ Preferred Name:______________

Birth date:______________ SS #:_____________________ Age:_____ Sex:_____ Marital Status:_______

Mailing Address:____Zip code:_________

Home Phone:____________ Cell Phone:_____________ Work Phone:___________E-mail:______________

Employer:___________________________ Employer Address:_______________________________________

PART 2: *PERSON PAYING* FOR DENTAL SERVICES (leave blank if same as above)

Full Name of Person Paying for Dental Services:____

Birth date of Person Paying for Dental Services:____

SS # of Person Paying for Dental Services:____

Address of Person Paying for Dental Services:____

Employer Name/ Address/ Phone:____

____

PART 3: DENTAL INSURANCE

Name of Insured:_____________________________Employer:____

Insured Birth Date:_____________ SS#:_________________ Relationship to Patient:____________________

Insurance Company Name/Address:____

Insurance Company Phone:_________________________________ Group Number:______________________

Part 4: SECONDARY DENTAL INSURANCE (leave blank if no secondary insurance)

Name of Insured:______________________Phone #:__________Employer:______________________________

Insured Birth Date:______________ _SS#:_______________Relationship to Patient:______________________

Insurance Company Name/Address:____

Insurance Company Phone:_________________________________ Group Number:______________________

PART 5: PATIENT MEDICAL HISTORY

Are you under a physician's care now?_______________Have you ever had a serious head or neck injury?______

Any history of joint or heart valve replacement?___________Do you use tobacco?_____ Any history of substance abuse?____ Are you pregnant/nursing/taking oral contraceptives?______ Do you take a blood thinner?_________

Do you have sleep apnea?______ List all prescription and non-prescription medications ______________________

____

Circle any you are allergic to: **Aspirin Codeine Penicillin Erythromycin Tetracycline Metal Dental Anesthetics Sulfa Drugs** **List any other medications you are allergic to:__________________________________**

Have you ever taken Fosomax, Boniva, Actonel or any other medications containing bisphosphonates? __________

List any health problems you have had within the last 10 years:____

____

Circle any that apply to you: **AIDS/HIV Artificial Joint Artificial Valve Asthma Cancer Chemotherapy Fever Blisters Diabetes Drug Addiction Excessive Bleeding Frequent Headaches Heart Attack Pacemaker Heart Murmur Hepatitis High Blood Pressure Low Blood Pressure Liver Disease Anxiety Psychiatric Problems Mitral Valve Prolapse Radiation Treatments Stomach/Intestinal Disease Sinusitis Jaw pain**

Family Doctor:________________ Emergency contact/number/relationship:_________________________________

PART 6: AGREEMENT TO PAY FOR DENTAL SERVICES

I understand I am responsible for all charges incurred regardless of insurance coverage. I understand I have a co-pay for most services and payment is due at the time of service. I agree to pay any outstanding balance within 30 days after payment is made or denied by my insurance company. I understand it my sole responsibility to know the provisions and limitations of my insurance plan. I understand a billing charge of $5.00 and finance charge of 1 1/2% per month (18% annually) will be added to any account over 60 days past due. I understand any account greater than 90 days old is subject to collection proceedings and that I am responsible for any collection costs incurred by Max L. Lingo, D.D.S. ***I agree to be contacted at any telephone number associated with my account including wireless; and also by text messages or e-mail. I understand methods of contact may include using prerecorded/artificial messages and or use of an Automatic Dialing Service as applicable.***

PART 7: ASSIGNMENT OF BENEFITS

I authorize the insurance company(s), employee benefit plan and or third party to send payment directly to Max L. Lingo, D.D.S. ***If benefits are sent to the insured I will immediately deliver them to Max L. Lingo, D.D.S.***

PART 8: AUTHORIZATION TO RELEASE INFORMATION:

I authorize Max L. Lingo, D.D.S. to release my dental records as necessary to receive payment for services. I relieve Max L. Lingo, D.D.S from any legal liability that may arise from the release of my dental record.

Part 9: ACKNOWLEDGMENT OF PRIVACY PRACTICES

I have been offered and/or received a copy of Max L. Lingo, D.D.S.'s Notice of Privacy Practices.

A $100 FEE WILL BE ASSESSED PER FAILED APPOINTMENT.48 HOURS NOTICE IS REQUIRED FOR APPOINTMENT CANCELLATIONS. UNDER 48 HOURS NOTICE IS A FAILED APPOINTMENT AND SUBJECT TO $100 FEE. IF TWO APPOINTMENTS ARE FAILED NO ADDITIONAL SERVICES WILL BE AVAILABLE TO ANY FAMILY MEMBERS. **Please sign and date both lines.**

SIGNATURE OF PATIENT:____ DATE:______

SIGNATURE OF RESPONSIBLE PARTY:_______________________________________ DATE:______