Patient Registration Form

Roxanne Siegrist, DDS | 510 Elk Avenue | Suite 2 | Crested Butte, CO 81224

Patient information

First name: _____ Preferred name: _____

Last name: _____ Birth date: _____

Mailing address: _____ E-mail address: _____

City: _____ Home phone: _____

State: _____ Cellular phone: _____

Zip code: _____ Work phone: _____

Sex: _____ Driver's license #: _____

Marital status: _____ Referred from : _____

Patient social security number (required for filing insurance): _____

Preferred contact method for appointment confirmation: ☐ phone ☐ text ☐ e-mail

Person responsible for account (if different from patient)

First name: _____ Relationship: _____

Last name: _____ Birth date: _____

Mailing address: _____ E-mail address: _____

City: _____ Home phone: _____

State: _____ Cellular phone: _____

Zip code: _____ Work phone: _____

Insurance information:

Primary dental insurance

Subscriber name: _____

Subscriber DOB: _____

Subscriber SS#: _____

Subscriber ID: _____

Group name: _____

Carrier name: _____

Carrier phone: _____

Patient relationship to subscriber:

☐ self ☐ spouse ☐ child

Secondary dental insurance

Subscriber name: _____

Subscriber DOB: _____

Subscriber SS#: _____

Subscriber ID: _____

Group name: _____

Carrier name: _____

Carrier phone: _____

Patient relationship to subscriber:

☐ self ☐ spouse ☐ child

Date:

Patient or guardian signature:

Medical History

Roxanne Siegrist, DDS | 510 Elk Avenue | Suite 2 | Crested Butte, CO 81224

Last name: _____ Physician name: _____

First name: _____ Physician City/State: _____

Date of birth: _____ Date last visit to physician: _____

Emergency contact: _____ Phone: _____ Relationship: _____

Check any of the following that apply:

Y	N		Y	N		Y	N	
☐	☐	Blood thinner	☐	☐	Pain medication	☐	☐	Osteoporosis medication
☐	☐	Pregnant	☐	☐	Nursing	☐	☐	Birth control medication

Due date: _____

List all current medications:

_____

_____

_____

_____

_____

_____

_____

_____

Are you allergic to any of the following?

Y	N		Y	N		Y	N		Y	N	
☐	☐	Amoxicillin	☐	☐	Codeine	☐	☐	Ibuprofen	☐	☐	Penicillin
☐	☐	Aspirin	☐	☐	Demerol	☐	☐	Iodine	☐	☐	Septocaine
☐	☐	Augmentin	☐	☐	Epinephrine	☐	☐	Latex	☐	☐	Sulfa
☐	☐	Cephalospori	☐	☐	Erythromycin	☐	☐	Morphine	☐	☐	Tetracycline
☐	☐	Clindamycin	☐	☐	Gold	☐	☐	Nickel	☐	☐	Vicodin

☐ ☐ Other: _____

Do you have any of the following medical conditions?

Y	N		Y	N		Y	N	
☐	☐	Acid reflux	☐	☐	Excessive bleeding	☐	☐	Pacemaker
☐	☐	Anemia	☐	☐	Fainting	☐	☐	Persistent cough
☐	☐	Arthritis	☐	☐	Fibromyalgia	☐	☐	Persistent swollen glands
☐	☐	Asthma	☐	☐	Glaucoma	☐	☐	Radiation treatment
☐	☐	Blood disease	☐	☐	Gout	☐	☐	Respiratory problem
☐	☐	Blood pressure HIGH	☐	☐	Head injuries	☐	☐	Seizures
☐	☐	Blood pressure LOW	☐	☐	Heart disease	☐	☐	Sexually transmitted disease
☐	☐	Blood transfusion	☐	☐	Heart valve problem	☐	☐	Sinus trouble
☐	☐	Cancer	☐	☐	HIV / AIDS	☐	☐	Stroke
☐	☐	Chemotherapy	☐	☐	Immunity problem	☐	☐	Thyroid disorder
☐	☐	Chronic pain	☐	☐	Jaundice	☐	☐	Tobacco use: current
☐	☐	Chronic headache	☐	☐	Kidney disease	☐	☐	Tobacco use: former
☐	☐	Diabetes	☐	☐	Liver disease	☐	☐	Tuberculosis
☐	☐	Dry mouth	☐	☐	Mental disorder	☐	☐	Tumor
☐	☐	Eating disorder	☐	☐	Neurological disorder			

☐ ☐ Artificial joint (joint and date): _____

☐ ☐ Hospitalized or surgery last two years (reason): _____

☐ ☐ Hepatitis: ☐ A ☐ B ☐ C

☐ ☐ OTHER CONDITIONS (list): _____

Date: _____

Patient or guardian signature: _____ Doctor signature: _____

Dental History

Roxanne Siegrist, DDS | 510 Elk Avenue | Suite 2 | Crested Butte, CO 81224

Last name: _____

First name: _____

Date of birth: _____

Pre-medication for dental procedures:

Have you ever been told to pre-medicate for dental procedures? ☐ Yes ☐ No

If yes, what medications: ☐ Amoxicillin ☐ Clindamycin ☐ Unknown ☐ Other: _____

If yes, for what conditions: _____

Dental history:

Reason for today's visit: _____

Current dental pain? _____

Trouble with previous dental treatment? _____

Unusual reactions to dental injections?: _____

Adverse reactions to painkillers or antibiotics? _____

Have you had your 3rd molars (wisdom teeth) extracted? _____

Do you have any dental implants? _____

Do you have any facial implants? _____

Do you wear complete or partial dentures? _____

Panoramic or full mouth radiographs fewer than 5 years old? _____

Bitewing radiographs within last year? _____

Date of last cleaning and exam: _____

Former dentist name: _____

Former dentist city / state: _____

Date: _____

Patient or guardian signature: _____ Doctor signature: _____

Financial Agreement

Roxanne Siegrist, DDS | 510 Elk Avenue | Suite 2 | Crested Butte, CO 81224

For all patients:

I agree to pay for my services on the day that they are rendered.

I understand that if I begin major treatment that involves lab work, I will be responsible for the laboratory fee at the time that the service is BEGUN.

If sent to collections, I agree to pay all related court costs and fees, including a $100 fee to cover the cost of collections efforts.

Treatment plans and cost estimates may change, and I will be financially responsible for the work actually done.

For patients with insurance:

For my convenience, this office may release my information to my insurance company, and receive payment directly from them.

I will pay the estimated patient portion for services at the time of service, but I will still be responsible for the full fee if insurance pays less than expected. If I do not wish to pay the estimated patient portion before claims are processed, I must allow credit card information to be stored and charged without further permission after claims are processed (but we will still send you a bill before we resort to this).

I am responsible for understanding my insurance benefits, including, but not limited to, any frequency limitations, waiting periods, deductibles, co-pays, maximums, and non-covered services, and I will be financially responsible for the full fee in the event that no or reduced insurance benefits are paid for my services, regardless of whether the dental staff informs me of such limitations (but we try our best to let you know about these ahead of time).

I understand that no dental insurance pays 100% for all dental services, and that insurance benefits for major services are often as low as 50% of the fee.

For patients with Medicaid:

I understand that after Medicaid pays $1000 for an adult within a benefit year, I will pay regular office fees for any services resulting in charges exceeding that maximum.

I understand that I may request certain services (such as nitrous oxide sedation for adults) or materials that are not covered as a Medicaid benefit, and that I will be responsible for these charges.

I will pay the full fee for services if Medicaid coverage is not active on the day of service, and I am responsible for verifying the status of my coverage.

I understand that Medicaid limits the frequency of services and limits the frequency with which previous work can be repaired, and that I must provide written documentation of the dates of previous services paid for by Colorado Medicaid at other dental offices. If I do not provide such documentation, I will pay for services that are denied based on such limitations.

Today's date: _____

Patient name: _____

Patient date of birth: _____

Patient or guardian signature: _____

HIPAA Consent

Roxanne Siegrist, DDS | 510 Elk Avenue | Suite 2 | Crested Butte, CO 81224

Authorization

I have had the opportunity to read and consider the contents of the NOTICE OF PRIVACY PRACTICES for the office of Dr Roxanne Siegrist, which may be available in print form in the office, on the website for the office, or as an e-mail attachment. I understand that by signing this form I am giving my Authorization to this office to use and disclose my protected health information to carry out treatment, payment activities, and healthcare operations as specified in the NOTICE.

Today's date: _____

Patient name: _____

Patient date of birth: _____

Patient or guardian signature: _____

Consent for Nitrous Oxide Sedation

Roxanne Siegrist, DDS | 510 Elk Avenue | Suite 2 | Crested Butte, CO 81224

Authorization:

I hereby authorize Dr Roxanne Siegrist and staff to perform nitrous oxide sedation.

I understand that the administration and performance of conscious sedation with nitrous oxide carries infrequent hazards, risks, and potential side effects. These include, but are not limited to:

EXCESSIVE PERSPIRATION
Sweating may occur during the procedure and you may become somewhat flushed during administration of nitrous oxide.

EXPECTORATION
Removal of secretion may be difficult but can be controlled by use of suction tip.

BEHAVIORAL PROBLEMS
You may become difficult to treat because you become takative or you may experience vivid dreams associated with physical movement of your body.

SHIVERING
Shivering sometimes develops at the end of the sedative procedure when nitrous oxide has been terminated.

NAUSEA AND VOMITING
It is important to tell a staff member if you experience some discomfort, so that the level of nitrous oxide can be adjusted.

IMPAIRED OPERATION OF MOTOR VEHICLES
If you do not feel capable of driving after nitrous oxide administration, remain in the office until you feel better or a driver arrives.

I have been advised of alternative treatment, the benefits and risks which include, but are not limited to:
Fear and anxiety of the dental experience and/or avoidance of future dental appointments. These fears and anxiety, if not diminished by the use of nitrous oxide sedation, may precipitate other medical problems, including fainting, palpitation, and other heart-related disorders.

The benefits one can expect from nitrous oxide sedation include:
Help with anxiety, pain, gagging, and medically compromised individuals.

I understand this Authorization and the reasons for this sedative procedure and the associated risks. I understand that no guarantees are made as to the results of this procedure.

Today's date: _____

Patient name: _____

Patient date of birth: _____

Patient or guardian signature: _____