Williamsburg Periodontics

Michael Schroer, DDS

Patient Registration Form

PATIENT INFORMATION

Last Name_____ First Name_____ Middle Initial_____

Sex: Male ☐ Female ☐ Date of Birth_____ SS#_____

Address_____City_____State_____ZIP_____

Home Phone_____ Cell Phone_____ Work Phone_____

Email Address_____ Employer_____

Emergency Contact_____ Phone _____

RESPONSIBLE PARTY (if different from the patient)

Last Name_____ First Name_____ Middle Initial_____

Address_____City_____State_____ Zip_____

SS#_____ Date of Birth_____ Relationship to Patient_____

Home Phone_____ Cell Phone_____ Work Phone_____ Employer_____

PRIMARY INSURANCE INFORMATION

Subscriber Name_____ Relationship to Patient_____

Date of Birth_____ SS#_____ Sex: Male ☐ Female ☐

Insurance Co._____Policy#_____Group#_____

Claim Address_____Phone_____

Employer_____

SECONDARY INSURANCE INFORMATION

Subscriber Name_____ Relationship to Patient_____

Date of Birth_____ SS#_____ Sex: Male ☐ Female ☐

Insurance Co._____Policy#_____Group#_____

Claim Address_____Phone_____

Employer_____

461 McLaws Circle, Suite 1
Williamsburg, VA 23185
Phone: 757-221-0249

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Medical History

Name_____ Date of Birth_____ Today's Date_____

Name of Dentist_____ Phone_____

Name of Physician_____ Phone_____

Have you seen a physician for a medical condition in the last 6 months? ____ If so, when and why_____

Have you had an operation, illness or been hospitalized in the last five years?_____ If so, when and why_____

Have you ever had oral or I.V. bisphosphonate therapy (Actonel, Boniva, Fosamax, Skelid, Didronel, Aredia, Zometa, Bonefos, Prolia, etc.)? _____ If so, when and for how long did you have this treatment_____

Have you ever been instructed to premedicate with antibiotics prior to dental treatment for any condition such as a heart murmur, artificial joints, Rheumatic Fever, Etc.?_____

Please list all prescription and over the counter medications you are taking:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Cardio Vascular

- ☐ High Blood Pressure
- ☐ Heart Attack
- ☐ Angina/Chest Pain
- ☐ Damaged Heart Valves
- ☐ Heart Murmur
- ☐ Mitral Valve Prolapse
- ☐ Rheumatic Fever
- ☐ Congenitial Heart Defect
- ☐ Irregular Heart Beat
- ☐ Pacemaker
- ☐ Heart Surgery
- ☐ Other_____

Skin/Musculoskeletal

- ☐ Arthritis
- ☐ Back or Neck Problem
- ☐ Artificial Joint, if so when and what joint_____

Nerves/Sensory

- ☐ Epilespy/Seizures
- ☐ Fainting/Dizziness
- ☐ Nervousness
- ☐ Numbness/Tingling

Respiratory

- ☐ Bronchitis/Chronic Cough
- ☐ Sinus Problems
- ☐ Tuberculosis(TB)
- ☐ Asthma

Endocrine

- ☐ Diabetes
- ☐ Thyroid Disease

Hematologic

- ☐ Anemia
- ☐ Prolonged Bleeding
- ☐ Take Blood Thinners
- ☐ HIV/AIDS Positive
- ☐ Stroke

Gastrointestinal

- ☐ Gastric Reflux
- ☐ Gastric Bypass Surgery
- ☐ Stomach Ulcers
- ☐ Liver Disease
- ☐ Hepatitis

Urinary

- ☐ Kidney Problems

Other Conditions

- ☐ Mental Health Issues
- ☐ Eye Disease/Tumors
- ☐ Alcohol Abuse
- ☐ Drug Abuse
- ☐ Excessive Snoring
- ☐ Cortisone Treatment
- ☐ Cancer/Tumors
- ☐ Radiation/Chemotherapy
- ☐ Tobacco Use

Allergies

- ☐ Aspirin
- ☐ Codeine
- ☐ Dental Anesthetics
- ☐ Erythromycin
- ☐ Latex
- ☐ Penicillin
- ☐ Tetracycline
- ☐ Other_____

Please list any other medical conditions or concerns not mentioned above that the Dr. should be aware of_____

_____

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Financial Policy

Thank you for choosing our office for your dental health care needs. Please read and sign our financial policy before seeing the doctor. We would be happy to answer any questions you may have.

Payment is due at the time of Service. We accept Cash, Check, Visa, Mastercard, and Discover Card. We also accept Care Credit for transactions over $300.

Regarding Insurance:

- We are an In-Network provider for Delta Dental Insurance only, however, we will file insurance claims for all insurance companies as a courtesy.

- Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. While filing insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date services are rendered.

- If your insurance carrier is out-of network, all fees are due at time of service. Insurance will be filed and any benefits due will be sent directly to you by your insurance company.

- **Delta Dental Patients** will pay all co-pays, deductibles, and non covered service fees at time of service. If the insurance company does not pay in full within 30 days we ask that you contact the carrier to help speed things up. If the carrier does not pay in full within 45 days we require you to pay the entire account balance. We do not accept responsibility for your insurance companies delay on payment of your claim.

- Balances older than 90 days will be billed a finance charge of 1.5% per month and released to a collection agency until paid in full. Returned checks will have an additional processing fee of $30 and any future treatment would require payment by cash or credit card.

Appointments: Once an appointment has been made, please remember that this time has been reserved specifically for you. We reserve the right to charge a fee for any appointment missed or cancelled without 48 hours advanced notice. The missed appointment fee is $75 per scheduled hour with our Dental Hygienist and $100 for each hour scheduled with Dr Schroer.

I have read the financial policies and agree to abide by the terms outlined in the financial policy agreement. I understand and accept my financial responsibilities.

Signature_____ **Date**_____

Williamsburg Periodontics
Michael Schroer, DDS

HIPAA Notice of Privacy Practices
Acknowledgement of Receipt

I hereby acknowledge that I have read and received a copy of this office's HIPPA Notice of Privacy Practices.

Print Name_____ Date_____

Signed_____

I also give the office of Dr. Michael Schroer permission to speak to the following people (if any) regarding my dental health information:

_____

_____

_____

461 McLaws Circle, Suite 1
Williamsburg, VA 23185