Robert A. Ogie D.D.S.
Patient Registration

First Name____________________ Last Name____________________ Middle Initial______

Preferred Name____________________ Married__ Single___ Widowed___ Male___ Female___

Mailing Address______________________________ City______________ State_____ Zip______

Age____ Date of Birth______________ Home Phone______________ Cell______________

Do we have permission to leave a voicemail with appointment information Y______ N________

Employed by__________________________ Occupation______________________________

Social Security #__________________ Dental Insurance Co.______________________________

Group #__________________________ Identification #____________________________

Whom may we thank for referring you to our office?_________________________________

In case of Emergency, who should be notified?_______________________________________

If you are 18 or older you are the only one that can schedule appointments unless you list a personal representative.
Personal Representative____

Responsible Party Information (If Insured by somebody other than yourself)

First Name____________________ Last Name______________________________

Mailing Address_________________________ City________________ State_____ Zip________

Home Phone________________ Cell Phone_______________ Office Phone__________________

Date of Birth__________ Social Security #__________________ Employer___________________

Dental Insurance Co__________________ Group #______________

Identification # ______________________

I hereby authorize payment directly to the Dental office of the group insurance benefit otherwise payable to me. I understand that Iam responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and medical history are correct to the best of my knowledge.

Signature________________________________ Date_______________________

Robert Ogie, D.D.S.

Medical History

Patient Name:

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, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following

Question	Answer	
Are you under a physician's care now?	◯ 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
Have you ever taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ 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

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

AIDS/HIV Positive	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No	Alzheimer's Disease	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No	Anaphylaxis	◯ Yes ◯ No
Drug Addiction	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Anemia	◯ Yes ◯ No	Herpes	◯ Yes ◯ No
Rheumatic Fever	◯ Yes ◯ No	Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No
Epilepsy or Seizures	◯ Yes ◯ No	Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No
Shingles	◯ Yes ◯ No	Artificial Joint	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Asthma	◯ Yes ◯ No
Fainting Spells/Dizziness	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No	Blood Disease	◯ Yes ◯ No
Leukemia	◯ Yes ◯ No	Breathing Problems	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Genital Herpes	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Cancer	◯ Yes ◯ No
Thyroid Disease	◯ Yes ◯ No	Chemotherapy	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Chest Pains	◯ Yes ◯ No
Heart Attack/Failure	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No	Cold Sores/Fever Blister	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No
Pain in Jaw Joints	◯ Yes ◯ No	Congenital Heart Disorder	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Convulsions	◯ Yes ◯ No
Heart Trouble/Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Implants	◯ Yes ◯ No		

Have you ever had any serious illness not listed ◯ Yes ◯ No If yes

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:___________

Robert A. Ogie D.D.S
Office Policies

New Patients

Our primary purpose is to serve you and your family and to provide for your dental health needs in a considerate and caring fashion.

Office Hours

Monday-Thursday 8am—5pm closed for lunch 1pm—2pm Friday by Appointment

Payments and Collection

Payment is expected the day services are rendered. In the event of default of payment,and any balance not covered by insurance that is over 90 days past due, your account will be turned over to the collection agency. The responsible party will pay all reasonable court cost, attorney fees and/or collection fees incurred. In the event that I/we have failed to pay for the services provided by this office,and the account is placed for collection,I/we understand and agree that an additional amount equal to 40% of the balance owing at the time the account is placed for collection will be added to the current balance owing. In addition to a collection fee of 40% of the balance owed interest at the rate of 10% will be added until the amount owed is paid in full.

Insurance

If you have insurance ,we will gladly process your forms, however ,we request that you pay your estimated portion when services are rendered. Please remember that our contract for payment is with you and not your insurance carrier. We are happy to bill your insurance as a courtesy to you, when you have provided us with your complete insurance information. We allow 45 days from the date of service for payment from an insurance company. After this period, we ask you to become responsible for payment of all unpaid fees.

Cancelled / Missed Appointments

We reserve the right to charge $40.00 for any appointments cancelled or broken without a 24 hours advanced notice, also if you fail 3 appointments without proper notice we will no longer be able to see you in this office.

Children

Parents or guardians must wait in the waiting area while their children are in the back seeing the dentist. It is against the law for the dentist to treat children under the age of 18 years old without a legal guardian or parent in the office. Patients are the only ones allowed in the back and in the operatory while the dentist is treating patients.

Date:________________

Sign:________________

Print Patient/Responsible Name________________________

Robert A. Ogie D.D.S
Patient Consent / Acknowledgment Form

By signing below, you consent to the use and disclosure of your protected health information by Dr. Ogie, our staff, and our business associates for treatment, payment and healthcare operations. For a more detailed description of uses and disclosure for these purposes; please review our Notice of Privacy Practices. You have the right to review our Notice prior to signing this consent. The terms of this Notice may change. We will post any revised Notice in the office.

You have the right to request that we restrict our uses or disclosure of your protected health information that we are otherwise permitted to make for treatment,payment and healthcare operations, although we are are not required to agree to these restictions.
However, if we agree to further restictions, they are binding on us. Finally, you may refuse to consent to the use or disclosure of your of your protected health information, but this must be in writing. Under the law, we have the right to refuse to treat you should you choose to refuse to disclosure your Protected Health Information (PHI).

This form is also used to obtain consent/acknowledgement of receipt of our notice of privacy practices.

Patient Signature______________________________Date____________________

Patients name printed____

If this consent /acknowledge is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name____

Relationship to Patient____