Print Form

REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date_____

SS#_____

Patient Name_____

Address_____

City_____State_____Zip_____

How Long?_____ Rent ☐ Own☐

E-mail_____

Sex ☐M ☐F Age_____

Birth Date_____

☐Married ☐Widowed ☐Single ☐Minor

☐Separated ☐Divorced ☐Partnered For____Years

Employer _____

Whom may we thank for referring you?_____

HIPPA RELEASE AND CONSENT:

Acknowledgement of Receipt of Notice of Privacy Policies
I,_____, have received a copy of Dr. Caryl Earp's, Notice of Privacy Policies. I understand Dr. Earp may use my health care information and may disclose such information for treatment, payment, and health care operations.

_____Printed Name

_____ Signature & Date_____

2 DENTAL INSURANCE

Who is financially responsible for this account?

_____

Relationship to Patient_____

Insurance Co._____Group#_____

Employer _____

Is patient covered by additional insurance? ☐Yes ☐No

Subscriber's Name_____

Birth Date_____ SS#_____

Relationship to Patient_____

Insurance Co._____

Group #_____

Insurance Assignment
I certify that I, and/or my dependents(s), have insurance coverage

with_____and assign directly to
Name of insurance company(ies)

Dr. Caryl Earp & Associates all insurance benefits, if any, otherwise payable to me for services rendered.

Financial and Personal Health Information
Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company...not All Smiles Family Dentistry. If your insurance company has not reimbursed our office in full within 90 days, you will be responsible for the remainder of the balance. Thank you for your consideration.

I understand that I am financially responsible for all charges incurred dur-ing treatment. I understand that finance charges will be 90 days from the date of service if the balance is not paid in full. I authorize the use of my signature on all insurance submissions.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

3 PHONE NUMBERS

Home (_____)_____Work (_____)_____Ext _____ Cell Phone (_____)_____

Spouse's Work (_____)_____Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name_____ Relationship_____

Home Phone (_____)_____ Work Phone (_____)_____

4 HEALTH HISTORY UPDATE

Physician's Name _____ Date of last visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include conbinations of Ionamin, Adipex, Fastin (names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐Yes ☐No

Have you had any serious illnesses or operations? ☐Yes ☐No If yes, describe _____

Have you ever had a blood transfusion? ☐Yes ☐No If yes, give approximate dates _____

(Women) Are you pregnant? ☐Yes ☐No Nursing? ☐Yes ☐No Taking birth control pills? ☐Yes ☐No

5 DENTAL HISTORY

Reason for today's visit_____
Former Dentist_____
City/State_____
Date of last dental visit_____
Date of last dental X-rays_____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad Breath	☐Yes	☐No
Bleeding Gums	☐Yes	☐No
Blisters on lips or mouth	☐Yes	☐No
Burning sensation on tongue	☐Yes	☐No
Chew on one side of mouth	☐Yes	☐No
Cigarette, pipe, or cigar smoking	☐Yes	☐No
Clicking or popping jaw	☐Yes	☐No
Dry Mouth	☐Yes	☐No
Fingernail Biting	☐Yes	☐No
Food collection between the teeth	☐Yes	☐No
Foreign Objects	☐Yes	☐No
Grinding Teeth	☐Yes	☐No
Gums swollen or tender	☐Yes	☐No
Jaw pain or tiredness	☐Yes	☐No
Lip or cheek biting	☐Yes	☐No
Loose teeth or broken fillings	☐Yes	☐No
Mouth Breathing	☐Yes	☐No
Mouth pain, brushing	☐Yes	☐No
Orthodontic Treatment	☐Yes	☐No
Pain around ear	☐Yes	☐No
Periodontal Treatment	☐Yes	☐No
Sensitivity to cold	☐Yes	☐No
Sensitivity to heat	☐Yes	☐No
Sensitivity to sweets	☐Yes	☐No
Sensitivity when biting	☐Yes	☐No
Sore or growths in your mouth	☐Yes	☐No

How often do you brush/floss?_____/_____
Are you satisfied with the appearance of your teeth?_____

6 HEALTH HISTORY

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	☐Yes	☐No
Anemia	☐Yes	☐No
Arthritis, Rheumatism	☐Yes	☐No
Artificial Heart Valves	☐Yes	☐No
Artificial Joints	☐Yes	☐No
Asthma	☐Yes	☐No
Back Problems	☐Yes	☐No
Bleeding abnormally, with extractions or surgery	☐Yes	☐No
Blood Disease	☐Yes	☐No
Cancer	☐Yes	☐No
Chemical Dependency	☐Yes	☐No
Chemotherapy	☐Yes	☐No
Circulatory Problems	☐Yes	☐No
Congenital Heart Lesions	☐Yes	☐No
Cortisone Treatments	☐Yes	☐No
Cough, Persistent/Bloody	☐Yes	☐No
Diabetes - Type_____	☐Yes	☐No
Emphysema	☐Yes	☐No
Epilepsy	☐Yes	☐No
Fainting or Dizziness	☐Yes	☐No
Glaucoma	☐Yes	☐No
Headaches	☐Yes	☐No
Heart Murmur	☐Yes	☐No
Heart Problems	☐Yes	☐No
Hepatitis - Type_____	☐Yes	☐No
Herpes	☐Yes	☐No
High Blood Pressure	☐Yes	☐No
Jaundice	☐Yes	☐No
Jaw Pain	☐Yes	☐No
Kidney Disease	☐Yes	☐No
Liver Disease	☐Yes	☐No
Low Blood Pressure	☐Yes	☐No
Mitral Valve Prolapse	☐Yes	☐No
Nervous Problems	☐Yes	☐No
Take Oral Bisphosphates	☐Yes	☐No
Take IV Bisphosphates	☐Yes	☐No
Pacemaker	☐Yes	☐No
Psychiatric Care	☐Yes	☐No
Radiation Treatment	☐Yes	☐No
Respiratory Disease	☐Yes	☐No
Rheumatic Fever	☐Yes	☐No
Scarlet Fever	☐Yes	☐No
Shortness of Breath	☐Yes	☐No
Sinus Trouble	☐Yes	☐No
Skin Rash	☐Yes	☐No
Special Diet	☐Yes	☐No
Stroke	☐Yes	☐No
Swollen Feet or Ankles	☐Yes	☐No
Swollen Neck Glands	☐Yes	☐No
Thyroid Problems	☐Yes	☐No
Tonsillitis	☐Yes	☐No
Tuberculosis	☐Yes	☐No
Tumor or growth on head or neck	☐Yes	☐No
Ulcer	☐Yes	☐No
Venereal Disease	☐Yes	☐No
Weight Loss (unexplained)	☐Yes	☐No

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:_____

_____

_____

Pharmacy Name_____

Phone (___)_____

ALLERGIES

☐Aspirin
☐Barbiturates (Sleeping pills)
☐Codeine
☐Iodine
☐Latex
☐Local Anesthetic
☐Penicillin
☐Sulfa
☐Other_____

DATE: _____

TRUTH IN LENDING
EXPLANATION OF INTEREST RATES, INTEREST CHARGES AND FEES

INTEREST RATES AND INTEREST CHARGES	
Annual Percentage Rate (APR) for Purchases	**15.00%**
Paying Interest	A finance charge is imposed on those charges not paid in full within 30/60/90/120 days (as shown on the front of your billing statement) of the date you were first billed for the charges. The balance on which any finance charge is computed is determined by totaling the charges not paid within the time period shown on the front of your billing statement and then by multiplying the balance by the periodic rate shown.
Minimum Interest Charge	**If you are charged interest, the charge will be no less than $1.00**

FEES	
Late Charge	**$5.00 or 5% of the past due minimum payment, whichever is greater, with a maximum of $25.00**
Non-Sufficient Funds (NSF) Fee	**$10.00 per payment**

YOUR BILLING RIGHTS UNDER THE FAIR CREDIT BILLING ACT

If you think you have been billed incorrectly, or if you need more information about a transaction on your bill, write to us on a separate sheet at First Pacific Corporation, PO Box 3000, Salem, OR 97302. We must hear from you no later than 60 days after we have sent you the first bill on which the error or problem appeared. You may telephone us at 1-800-574-7064, but doing so will not preserve your rights. In your letter, please include the following information:

- Your name and account number.
- The dollar amount of the suspected error.
- Describe the error and explain why you believe there is an error. If you need more information, describe the item you are not sure about.

YOUR RIGHTS AND OUR RESPONSIBILITIES AFTER WE RECEIVE YOUR WRITTEN NOTICE

- We must acknowledge your letter within 30 days, unless we have corrected the error by then. Within 90 days, we must either correct or explain why we believe the error was correct.
- After we receive your letter, we cannot try to collect any amount you question, or report you as delinquent. We can continue to bill you for the amount in question, including finance charges and we can apply any amount against your credit limit. You do not have to pay any questioned amount while we are investigating, but you are still obligated to pay the parts of your bill that are not in question.
- If we find that we made a mistake on your bill, you will not have to pay any finance charges related to any questioned amount. If we didn't make a mistake, you may have to pay finance charges, and you will have to make up any missed payments on the questioned amount. In either case, we will send you a statement of the amount you owe and the date that it is due.
- If you fail to pay the amount that we think you owe, we may report you as delinquent. However, if our explanation does not satisfy you and you write to us within 10 days telling us that you still refuse to pay, we must tell anyone we report you to that you have a question about your bill and we must tell you the name of anyone we reported you to. When the matter is finally settled between us, we must tell anyone we report you to that it has been settled.
- If we don't follow these rules, we can't collect the first $50.00 of the questioned amount even if your bill was correct.
- Your continued use of this account constitutes your acceptance of the above stated conditions.

I agree to be responsible for all charges for dental services and material not paid by my dental benefits plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to any insurance claims.

I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.

All Smiles Family Dentistry . Dr. Caryl Ecarp.
Dental Entity Name

Signature _____ Date _____

Account Name _____ Address _____

A photocopy of this document may act as an original

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