Christine J. Coke, D.D.S., M.D., PA

PATIENT REGISTRATION

In order for us to file insurance claims and obtain balances correctly, please fill in all necessary information.
All patient information is confidential.

Today's Date _______________

Patient Name: ____ Drivers License # ___________
First Middle Initial Last

Social Security # _________________________________ Birthdate ______________________

Address: ____
Street Apt# City State Zip

Home Phone: ______________ Work Phone: _______________ Cell Phone: _______________

Employer: ____

Person to notify in case of emergency: _________________________ Phone: _______________

Guarantor's Name (If different from above) ____

Insured's SS # ___________________________________ Birthdate: _____________________

Address: _______________________________________ Drivers License # ________________

Home Phone: ____________________________ Work Phone: __________________

Employer: ____

DO YOU HAVE MEDICARE? (CIRCLE ONE) YES NO

MEDICAL	**DENTAL**
Do you have Medical insurance? Yes No	Do you have Dental Insurance? Yes No
PRIMARY MEDICAL INSURANCE INFO.	PRIMARY DENTAL INSURANCE INFO.
Insurance Company:_______________________	Insurance Company:___________________
Ins. Company Phone:______________________	Ins. Company Phone:___________________
Insured's Name___________________________	Insured's Name_______________________
Patient is: Self Spouse Child Other	Patient is: Self Spouse Child Other
Insured's SS # ____________________________	Insured's SS # ________________________
Insured's Birthdate_________________________	Insured's Birthdate______________________
Employer__________________________________	Employer_______________________________
Grp. Number_______________________________	Grp. Number____________________________
Mail Claims To:_____________________________	Mail Claims To:__________________________
____	_______________________________________

Patient Name:________________________

Christine J. Coke, DDS, MD, PA

Oral, Facial, and Dental Implant Surgery

Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the facial care that you will be receiving. Thank you for answering all of the following questions. Your answers are for our records only, and will be considered confidential. THANK YOU!

Reason for today's visit:____

Do you consider you reason for your visit to be: Medical or Dental

If medical, were you referred by your primary care physician? YES NO

Who is your primary care physician?____________________________________

Do you have a referral letter? YES NO

If dental, how were you referred to us?_________________________________

Whom may we thank?____

CURRENT DENTAL CONDITION:

Are you in pain?	YES	NO
Do you have trouble chewing or speaking?	YES	NO
Have you ever had periodontal (gum) treatments?	YES	NO
Do your gums bleed, feel tender or irritated?	YES	NO
Are teeth sensitive to hot, cold, sweets, pressure?	YES	NO
Do you wear dentures?	YES	NO
If yes, are you unhappy with your dentures?	YES	NO
Do you want to know about permanent replacements?	YES	NO
Are you apprehensive about dental treatment?	YES	NO
Do you have headaches, earaches, or neck pain?	YES	NO
Have you worn braces on your teeth?	YES	NO
Do you use cigars, cigarettes, a pipe, or chewing tobacco?	YES	NO

GENERAL HEALTH HISTORY

Have there been any changes in your general health in the past year? YES NO

If yes, what has changed?____

Have you had any illness, operation, or been hospitalized in the past five years?
YES NO

If yes, please list____

____

Has anyone in your family, including you, had anesthetic problems during an operation?
YES NO

Do you have unhealed injuries, inflamed areas, growths or spots in or around your mouth?
YES NO

PLEASE LIST ANY DRUGS YOU ARE CURRENTLY TAKING:

____

____

Have you had ALLERGIC REACTIONS to any drug? YES NO

If yes, which?____

What kind of reaction?____

____

Patient Name:________________________

INDICATE WHICH OF THE FOLLOWING YOU HAVE OR EVER HAD

Circle "Yes" on each appropriate item.

Heart Failure	YES	Hepatitis A (infectious)	YES	Psychiatric treatment	YES
Thyroid problems	YES	Hepatitis B (serum)	YES	High blood sugar/diabetes	YES
Heart disease or heart attack	YES	Hepatitis C	YES	Liver disease	YES
Kidney trouble	YES	Heart surgery	YES	Bruise easily	YES
Congenital heart disease	YES	Heart pacemaker	YES	Ulcers	YES
Stroke	YES	Rheumatic fever	YES	Alcoholism	YES
Angina pectoris	YES	Cold sores/fever blisters	YES	Chronic fatigue/night sweats	YES
Epilepsy or seizures	YES	Asthma	YES	Cancer	YES
Heart Murmur	YES	Venereal disease	YES	Chronic cough	YES
Sickle cell disease or trait	YES	Emphysema	YES	Chemotherapy	YES
High blood pressure	YES	Drug addiction	YES	Sinus trouble	YES
Anemia	YES	Tuberculosis	YES	Pain in jaw joints (TMJ)	YES
Low blood pressure	YES	X-ray treatment/Radiation	YES	Low blood sugar	YES
Hemophilia	YES	Hay fever	YES	Arthritis or Rheumatism	YES
Arteriosclerosis	YES	Profuse bleeding	YES	Artificial joint: hip, knee, etc.	YES
Blood transfusion	YES	Allergies or hives	YES	Cortisone medication	YES
Mitral valve prolapse	YES	Fainting or dizzy spells	YES	Wear glasses/contact lenses	YES
AIDS/RRC/HIV positive	YES	Nervousness	YES	Glaucoma	YES
Artificial heart valve	YES	Yellow jaundice	YES	Cosmetic surgery	YES

When you walk upstairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath or because you are very tired?	YES	NO
Do your ankles swell during the day?	YES	NO
Do you use more than two pillows to sleep?	YES	NO
Have you lost or gained more than 10 pounds in the last year?	YES	NO
Do you ever wake up from sleep and feel short of breath?	YES	NO

Are you on a special diet? YES NO

If yes, please explain____

____

Do you have or have you had any disease, condition, hospitalization or problem not listed here?
YES NO

If yes, please explain____

FOR WOMEN ONLY

Is there a possibility of pregnancy? YES NO

If yes, estimated delivery date?____

Are you nursing? YES NO

Are you taking birth control pills? YES NO

Women Note: Antibiotics may alter the effectiveness of birth control pills. Consult your physician or gynecologist for information regarding additional methods of birth control.

CONSENT

I certify that all above questions were answered truthfully and to the best of my knowledge with the understanding that they were necessary to provide quality dental care in a safe and efficient manner.

____

Patient Signature (or responsible party and relation to the patient) Date

____

Doctor Signature Date

FINANCIAL POLICY

Thank you for choosing Christine J. Coke, DDS, MD, PA as your oral surgery provider. We are committed to providing the best dental and medical care possible. Please understand that payment of your bill is considered a part of your treatment. The following statement explains our Financial Policy which we ask you read, sign and return to us prior to your treatment.

- All patients should provide accurate and complete personal and insurance information prior to being seen by the doctor. **PLEASE PROVIDE BOTH YOUR MEDICAL AND DENTAL INSURANCE CARDS.**
- All applicable co-pays, personal balances, both current and prior, are due at the time of service.
- We accept cash, check or credit cards including CareCredit. All checks are processed as electronic checks.

Regarding Insurance

We participate in most dental insurance plans; however we require the guarantor, the person who is financially responsible, is personally liable for any amount not covered by insurance. Please be aware that some, and perhaps all, of the service provided may be non-covered services or may not be considered medically/dentally necessary under your dental or medical plan. I also understand and acknowledge that I am personally responsible to pay Christine J. Coke, DDS, MD, PA in full for services that my dental/health insurer will not cover. I am also personally responsible for services that my dental/health insurer will not cover due to non-payment of my dental/health insurance premiums, including those premiums under the Affordable Care Act and Advance Premium Tax Credits. We do not participate in any medical insurance plans. Initials _____

In some cases, your dental policy may require that we submit a claim to your medical health insurance for dental procedures. As a courtesy, we will bill both medical and dental insurances for you. In the event that your medical insurance carrier pays for these services, they often are applied to your out-of-network deductible and you may be responsible for the full balance if your dental insurance does not subsequently pay their estimated portion. Initials _____

For patients with dual dental/medical coverage, we will bill both insurances for you. 50% of your primary co-pay will be due at time of service. After payment or denials from both insurances have been received, any balance remaining will be the guarantor's financial responsibility. In the event of a credit balance, a refund will be issued to the method of payment that was made at the time of service. Initials _____

Returned Checks

For checks returned to us as unpaid by your bank, we will charge a $25.00 fee. Initials _____

I have read the Financial Policy. I understand and agree to the Financial Policy.

____

Print Name

____

Signature Date