FOX RIVER VALLEY PROSTHODONTICS

TODAY'S DATE: _____

Patient Registration

ID: _____ Chart ID: _____

First Name: _____ **Last Name:** _____ **Middle Initial:** _____

Other Dentists, if applicable _____

Other Physicians Names _____

Whom may we thank for referring you to our practice? _____

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Street Address: _____ City, State, Zip: _____

Home Phone: _____ Work Phone: _____ (Ext:) _____ Cell: _____

Patient Information

Street Address: _____ City, State, Zip: _____

Home Phone: _____ Work Phone: _____ (Ext:) _____ Cell: _____

☐ Male ☐ Female ☐ Married ☐ Single Birth Date: _____ _ Spouse's Name: _____

Soc Sec # _____ Driver's License: _____ E-mail _____

Occupation: _____ Employer: _____

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired Height Feet: _____ Inches: _____

Student Status: ☐ Full Time ☐ Part Time Weight: _____

Medicaid ID: _____ Preferred Dentist: _____

Employer ID: _____ Preferred Pharmacy: _____

Carrier ID: _____

Primary Insurance Information

First Name of Insured: _____ Last Name: _____ Middle Initial: _____

Policy/Group No: _____ Relationship to insured: ☐ Self ☐ Spouse

Insurance ID No: _____ ☐ Child ☐ Other

Insured Soc Sec #: _____ Insured Birth Date: _____

Employer: _____	Insurance Company: _____
Insured Address (if different than patient's)	Street Address: _____
Street Address: _____	City, State, Zip: _____
City, State, Zip: _____	Phone: _____

Medical History Questionnaire

OFFICE USE
Patient ID: _____

This questionnaire was designed to provide important facts regarding the history of your condition. The information you provide will assist in reaching a diagnosis and determining the source of your problem. Please take your time and answer each question as completely and honestly as possible.

List any medications or substances which have caused an allergic reaction:

Yes ☐ No ☐ Antibiotics Yes ☐ No ☐ Codeine Yes ☐ No ☐ Metals
Yes ☐ No ☐ Aspirin Yes ☐ No ☐ Latex Yes ☐ No ☐ Penicillin
Other: _____

List any medication currently being taken:

Medication Name	Dosage/or Frequency	Reason

Please indicate dates on item marked current or past

Medical Condition	Never	Current	Past	Date	Medical Condition	Never	Current	Past	Date
Adenoids removed	____	_____	____	_____	Hypertension	____	_____	____	_____
Anemia	____	_____	____	_____	Insomnia	____	_____	____	_____
Arteriosclerosis	____	_____	____	_____	Intestinal disorders	____	_____	____	_____
Arthritis	____	_____	____	_____	Jaw joint surgery	____	_____	____	_____
Asthma	____	_____	____	_____	Kidney problems	____	_____	____	_____
Autoimmune disorder	____	_____	____	_____	Liver disease	____	_____	____	_____
Blood pressure – high	____	_____	____	_____	Multiple sclerosis	____	_____	____	_____
Blood pressure – low	____	_____	____	_____	Nasal allergies	____	_____	____	_____
Bruising easily	____	_____	____	_____	Needing extra pillow to help breathing at night	____	_____	____	_____
Cancer	____	_____	____	_____	Numbness of fingers	____	_____	____	_____
Chemotherapy	____	_____	____	_____	Osteoarthritis	____	_____	____	_____
Chronic fatigue	____	_____	____	_____	Osteoporosis	____	_____	____	_____
COPD	____	_____	____	_____	Parkinson's disease	____	_____	____	_____
Depression	____	_____	____	_____	Prior orthodontic treatment	____	_____	____	_____
Diabetes	____	_____	____	_____	Radiation treatment	____	_____	____	_____
Difficulty concentrating	____	_____	____	_____	Rheumatic fever	____	_____	____	_____
Difficulty sleeping	____	_____	____	_____	Rheumatoid arthritis	____	_____	____	_____
Emphysema	____	_____	____	_____	Scarlet fever	____	_____	____	_____
HIV (Aids)	____	_____	____	_____	Shortness of breath	____	_____	____	_____
Epilepsy	____	_____	____	_____	Sinus problems	____	_____	____	_____
Fibromyalgia	____	_____	____	_____	Sleep apnea	____	_____	____	_____
Glaucoma	____	_____	____	_____	Stroke	____	_____	____	_____
Gout	____	_____	____	_____	Tendency for ear infections	____	_____	____	_____
Hay fever	____	_____	____	_____	Tired muscles	____	_____	____	_____
Heart attack	____	_____	____	_____	Tonsils removed	____	_____	____	_____
Heart murmur	____	_____	____	_____	Tuberculosis	____	_____	____	_____
Heart pacemaker	____	_____	____	_____	Wisdom teeth (third molar) extraction	____	_____	____	_____
Heart valve replacement	____	_____	____	_____					
Hepatitis	____	_____	____	_____					
Other: _____		_____	____	_____	**Other:** _____		_____	____	_____
Other: _____		_____	____	_____	**Other:** _____		_____	____	_____

List any surgical operations you have had:

Nasal _____ Tonsillectomy _____ Uvulectomy _____ LUAP _____
Other: _____ _____ _____

Family History

Has any member of your family (parent, sibling, grandparent) had the following?

☐ Heart Disease ☐ Stroke
☐ Diabetes ☐ Obesity ☐ Father has sleep apnea
☐ High Blood Pressure ☐ Sleep Disorder ☐ Mother has sleep apnea

Social History

Cigarette Use: ☐ Smoked ☐ Never Smoked ☐ Quit
☐ Current Smoker Number of packs per day: ___ Number of years: ___
Other tobacco: ☐ Pipe ☐ Snuff ☐ Cigar ☐ Chew
Alcohol Use: If yes, please state the typical number of drinks per week ___, month ___, or year ____
Caffeine Intake: ☐ None ☐ Coffee/Tea/Soda # of cups per day: ____
Additional:

I authorize the release of a full report of examination findings, diagnosis, treatment program etc., to any referring or treating dentist or physician. I additionally authorize the release of any medical information to insurance companies or for legal documentation to process claims. I understand that I am responsible for all charges for treatment to me regardless of insurance coverage.

Patient Signature: _____ **Date:** _____
I certify that the medical history information is complete and accurate.

Patient Signature: _____ **Date:** _____

Christopher J. Glapa, D.D.S.

W3132 Van Roy Road

Appleton, WI 54915

920-734-7345

STATEMENT OF FINANCIAL RESPONSIBILITY

As a courtesy to you, our office will facilitate your care by providing assistance with any applicable insurance you may have: however, you must present accurate information regarding your coverage prior to your appointment. As you know, insurance companies vary widely in the types of coverage they provide. In cases where coverage is applicable, reimbursement will be delayed an average of 8-12 weeks. Therefore, we require your estimated patient portion on the day services are rendered.
Please realize that many insurance companies reimburse professional fees on a complicated fee averaging basis; this estimated reimbursement provided by your insurance company may or may not be representative of fees in the Appleton area. Unfortunately, we do not know the exact amount that your insurance company will pay because they only provide us an estimated fee for service. While our fees may be above or below the "usual and customary" rate provided to you by your insurance company, your portion is due in full at the time of your visit. In the event that your insurance company reduces or denies payment, you the responsible party, will be required to pay, all balances due from any treatment rendered.

Our staff is very experienced with insurance matters and can generally answer any questions you may have. While we do our best to maximize your insurance benefits, you are ultimately responsible for your financial obligation to this office. If you have questions or concerns regarding your insurance coverage or payment, please contact your insurance company directly. It is your responsibility to encourage your insurance company to pay in a timely manner.

You, the responsibility party, are obligated to pay in full at the time services are rendered. Financial arrangements are solely made by a written and signed agreement between the office manager and responsible party. All outstanding account balances are subject to the following: Any balance overdue past 30 days is subject to a monthly interest charge of 1% (12%APR), or maximum allowable by Wisconsin State Law. Outstanding estimated insurance balances do not accrue interest and are NOT subject to billing charges.

FILING INSURANCE CLAIMS IS A SERVICE PROVIDED BY OUR OFFICE FREE OF CHARGE AND IN NO WAY RELIEVES YOU OF RESPONSIBILITY FOR YOUR BILL.

Please proceed to the second page of this statement which immediately follows this page.

Your Rights
As a patient you have the right to:
* Receive quality health care
* Be treated with dignity and respect
* Obtain prompt and courteous treatment
* Expect total confidentiality
* Address complaints directly with Office Manager
Your Responsibilities
* Observe the right to privacy and confidentiality of other patients
* Respect the staff
* Follow all pre-operative, operative and post-operative instructions
* Ask questions if you do not understand policy or procedures
* Address all complaints directly with Office Manager
* Fully fill out your forms

PLEASE REALIZE THE IMPORTANCE OF THE MATERIALS (X-RAYS, DIAGNOSTIC CASTS, ETC.) NEEDED TO PROVIDE THE QUALITY CARE YOU DESERVE AND WE REQUIRE.
Your signature below acknowledges a complete understanding and agreement to the following:
* The 1% monthly finance per statement on overdue patient balances beyond 30 days.
*Authorization of direct payment to the office of Martin A. Denbar for any dental or medical reimbursements for services rendered.

* Your authorization for the release of medical or dental records or any other information necessary to expedite payment on your account.

* In case of default of payment on your account, you understand and agree to pay collection costs, attorney fees, and court costs incurred in collecting on any future outstanding balances.

Patient Signature: _____ Date: _____

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES
A copy of the NOTICE of PRIVACY PRACTICES is posted in the office. I understand that I am entitled to receive a copy of this document upon request.
Patient Signature: _____ Date:_____