PATIENT REGISTRATION

ID: _____ Chart ID: _____

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

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name: _____

Responsible Party (if someone other than the patient)

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

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ State / Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: _____ Age: _____ Soc Sec: _____ Drivers Lic: _____

E-mail: _____ ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg: _____

Section 3

EFFECTIVE DATE _____

SINGLE/FAMILY COV _____

EMERGENCY CONTACT _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Rem. Benefits: _____ Rem. Deduct: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Rem. Benefits: _____ Rem. Deduct: _____

TREY VEREEN, DMD

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

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 questions.

Are you under a physician's care now?	Yes No	If yes	
Have you ever been hospitalized or had a major operation?	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	
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes	
Are you on a special diet?	Yes No		
Do you use tobacco?	Yes No		
Do you use controlled substances?	Yes No	If yes	

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

Other? ☐ If yes

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

AIDS/HIV Positive	Yes No	Cortisone Medicine	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	Renal Dialysis	Yes No
Anemia	Yes No	Easily Winded	Yes No	Herpes	Yes No	Rheumatic Fever	Yes No
Angina	Yes No	Emphysema	Yes No	High Blood Pressure	Yes No	Rheumatism	Yes No
Arthritis/Gout	Yes No	Epilepsy or Seizures	Yes No	High Cholesterol	Yes No	Scarlet Fever	Yes No
Artificial Heart Valve	Yes No	Excessive Bleeding	Yes No	Hives or Rash	Yes No	Shingles	Yes No
Artificial Joint	Yes No	Excessive Thirst	Yes No	Hypoglycemia	Yes No	Sickle Cell Disease	Yes No
Asthma	Yes No	Fainting Spells/Dizziness	Yes No	Irregular Heartbeat	Yes No	Sinus Trouble	Yes No
Blood Disease	Yes No	Frequent Cough	Yes No	Kidney Problems	Yes No	Spina Bifida	Yes No
Blood Transfusion	Yes No	Frequent Diarrhea	Yes No	Leukemia	Yes No	Stomach/Intestinal Disease	Yes No
Breathing Problems	Yes No	Frequent Headaches	Yes No	Liver Disease	Yes No	Stroke	Yes No
Bruise Easily	Yes No	Genital Herpes	Yes No	Low Blood Pressure	Yes No	Swelling of Limbs	Yes No
Cancer	Yes No	Glaucoma	Yes No	Lung Disease	Yes No	Thyroid Disease	Yes No
Chemotherapy	Yes No	Hay Fever	Yes No	Mitral Valve Prolapse	Yes No	Tonsillitis	Yes No
Chest Pains	Yes No	Heart Attack/Failure	Yes No	Osteoporosis	Yes No	Tuberculosis	Yes No
Cold Sores/Fever Blisters	Yes No	Heart Murmur	Yes No	Pain in Jaw Joints	Yes No	Tumors or Growths	Yes No
Congenital Heart Disorder	Yes No	Heart Pacemaker	Yes No	Parathyroid Disease	Yes No	Ulcers	Yes No
Convulsions	Yes No	Heart Trouble/Disease	Yes No	Psychiatric Care	Yes No	Venereal Disease	Yes No
						Yellow Jaundice	Yes No

Have you ever had any serious illness not listed above? 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:_____

Trey Vereen, DMD PA 1522 Two Notch Rd SE Aiken, SC 29803

Authorization Form for Use or Disclosure of Patient Information

Patient Name:_____

Patient's Date of Birth:_____ Patient's Chart No.: _____

I hereby authorize the use and disclosure of the patient information as described below. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA Privacy regulations.

Purpose(s) of this use or disclosure: To disclose dental information to appointed patient representative(s) and/or other dental care providers in the case of referred treatment.

The following person(s) may receive this patient information:

_____

I understand that I may revoke this authorization at any time, and that my revocation is not effective unless it is in writing and received by the dental practice's Privacy Official at **Trey Vereen, DMD**. If I revoke this authorization, my revocation will not affect any actions taken by the dental practice before receiving my written revocation.

I understand that I may refuse to sign this authorization, and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

Signature of Patient or Patient's Personal Representative:

_____Date_____

If Personal Representative:

Print Name:_____

Signature:_____Relationship to Patient:_____

OFFICE POLICY

Trey Vereen, DMD

Revised March, 2019

Welcome to my practice of Family & Cosmetic Dentistry. My staff and I are pleased that you have given us the opportunity to provide your dental care. To inform you of our policy regarding appointments and the collection of fees, please read both sides of this letter and sign where indicated. If you have any questions feel free to let us know.

APPOINTMENTS

General – We recommend that your first appointment be made with our hygienist. This will allow the doctor to treatment plan your dental needs. We encourage our patients to schedule their hygiene appointments in advance as indicated by our hygienist. This will help to ensure that you are seen on a regular basis and that we are meeting your specific dental needs. However, if you are unable to schedule in advance, we will send you a card to remind you to call for an appointment.

CLINICAL TREATMENT – Once our treatment plan is established, we encourage you to schedule an appointment as soon as possible so that an emergency visit may be avoided. If there are questions regarding treatment, either my assistant or I will be happy to answer them in the treatment room; however, once the treatment begins, we ask that family members wait in the waiting room. This allows the doctor to concentrate on the patient. Our experience with children indicates that they do better whenever parents remain in the waiting room.

CONFIRMATION – As a courtesy to our patients, our office will try to confirm your appointment at least one business day in advance. Please let us know on the registration form any special requests or preferences regarding methods to be used to confirm your appointment.

CANCELLATION – It is the patient's responsibility to contact us if an appointment cannot be kept. We ask that **at least one business day notice** be given. However, we realize that emergencies and illness can happen without warning, so please call us as soon as possible. All communications regarding an appointment are documented in the patient's chart. **After two consecutive appointments missed or "no-showed", an up-front, non-refundable $100 deposit will be required to make a third appointment.** This deposit will go towards planned treatment, or be forfeited if this last appointment is again missed.

REGISTRATION

REGISTRATION – The patient's name should be written without abbreviation, and the date of birth given. Please fill out this form completely except for the insurance information section. Our staff will do that for you. On each visit you will be asked to verify all the information on your registration form.

RESPONSIBLE PARTY – If someone other than the patient is responsible for the account, that section must be completed and signed by that person. Statements, refunds, in the case of overpayment, will be

sent to the responsible party. We will not assume that the person providing insurance for the patient will also be the responsible party, unless it is so declared by the patient.

COLLECTION – INSURANCE

DENTAL INSURANCE – Even though our practice is an in-network provider for several PPOs, we still offer the service of filing any insurance claim as a courtesy to our patients. However, we ask that you **review the guidelines** of your insurance coverage every year, especially if you experience a change in your employment, or your insurance carrier. Please make us aware of any changes, so that your claim may be processed without delay. We will verify your coverage and receive a breakdown of benefits, however, without prior notice, we will be unable to accomplish this before treatment. **IN THIS CASE, THE PATIENT WILL BE REQUIRED TO PAY FOR SERVICES AT THE TIME OF TREATMENT AND RECEIVE AN INSURANCE REIMBURSEMENT LATER.**

Dental plans have become very complex and changeable, and our office cannot be held responsible for knowing all the particulars of the many plans. However, we desire that all our patients receive the maximum insurance benefit, so for major treatment plans, a pre-determination will be filed with your insurance. Our office strives to make treatment plans affordable for all our patients, using all available insurance benefits possible. **However, all patients should expect that their patient portion or deductible would be collected at the time of their treatment visit.**

COLLECTION – NO INSURANCE

Fees are expected to be paid when services are rendered. Our office staff will be happy to pre-determine an estimate fee for your treatment at your request. **Please be prepared each visit to remit your portion due.** We accept cash, check, Care Credit, Visa, MasterCard, and Discover credit cards.

FRAUDULENT CHECKS – Checks returned for any reason will be assessed a penalty totaling the bank return fee. The patient will be notified and will be expected to clear the account with cash, credit card or money order within 10 days.

COLLECTION COST – Accounts are considered past due if a patient fails to remit their balance within 30 days of receiving a statement. Past due accounts will be assessed a MINIMUM collection fee of 35% of the balance owed. This fee may increase if the doctor incurs additional cost for collection involving a collection service, magistrate's court or lawyer fees. Patients with delinquent account are subject to refusal of further treatment.

Our office is in compliance with the Health Insurance Portability and Accountability Act (HIPAA). Patients and/or their guardian can request a copy of our "Notice of Privacy Practices" and will be required to sign our "Consent for Use and Disclosure of Health Information" form either giving consent or refusal regarding the privacy of their information. This form is permanently placed in the patient's records.

Please sign below indicating that you have read this form and will comply with the above policies.

_____ Date____/____/____

Signature of Responsible Party/Patient

Epworth Sleepiness Scale[11]

How likely are you to nod off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times.

Even if you haven't done some of these things recently, try to work out how they would have affected you. It is important that you answer each question as best you can.

Use the following scale to choose the most appropriate number for each situation.

	Would never nod off 0	Slight chance of nodding off 1	Moderate chance of nodding off 2	High chance of nodding off 3
Sitting and reading				
Watching TV				
Sitting, inactive, in a public place (e.g., in a meeting, theater, or dinner event)				
As a passenger in a car for an hour or more without stopping for a break				
Lying down to rest when circumstances permit				
Sitting and talking to someone				
Sitting quietly after a meal without alcohol				
In a car, while stopped for a few minutes in traffic or at a light				

Add up your points to get your total score. A score of 10 or greater raises concern: you may need to get more sleep, improve your sleep practices, or seek medical attention to determine why you are sleepy.

Patient Consent for Use of Photography and Videography

Dr. Trey Vereen
15 Tea Olive Court Aiken, SC 29803
803.642.5747

Patient Name: _____
Date of Birth: _____
Phone Number: _____
Email Address: _____

At Dr. Vereen Dental, we often take photographs and/or videos of patient treatments and outcomes for purposes such as clinical documentation, education, marketing, and promotion, including use on our website, brochures, and social media platforms.

Please read the following statements carefully and indicate your consent below:

Consent and Authorization

I, the undersigned, hereby authorize **Dr. Vereen Dental** and its authorized representatives to take and use photographs, video recordings, and/or digital images of me, including images of my face, teeth, mouth, and treatment results.

I understand and agree that these images may be used for the following purposes:

- Educational presentations, including for other dental professionals
- Marketing and promotional materials, including but not limited to brochures, websites, and social media (e.g., Facebook, Instagram, etc.)
- Display in the dental office as examples of clinical work

I understand that:

1. **Confidentiality & HIPAA Compliance**: No full name or personal identifying information will be disclosed or used in connection with any images or videos without my explicit consent, in compliance with the Health Insurance Portability and Accountability Act (HIPAA).

2. **Voluntary Participation**: This authorization is voluntary and I may revoke it in writing at any time by submitting a request to the office. However, I understand that revocation will not apply to any information or images already used or disclosed.

3. **Compensation**: I will not receive financial compensation for the use of these images or recordings.

4. **Ownership**: All images and recordings taken shall be the property of Dr. Vereen Dental.

5. **Indefinite Use**: I authorize use of these materials indefinitely unless I revoke this consent in writing.

Consent and Release

☐ **YES**, I give consent for Dr. Vereen Dental to use my images/videos for the purposes described above.
☐ **NO**, I do not give consent.

Patient/Guardian Signature: _____
Print Name: _____
Date: _____

If Patient is a Minor, Parent/Guardian Name: _____

Relationship to Patient: _____