



PATIENT REGISTRATION

Today's Date _____

Patient First Name: _____ Patient Last Name: _____ Middle _____

Preferred Name: _____

Patient is : Responsible Party

Responsible Party: (Responsible Party is policy holder and/ or parent/ guardian of patient)

Patient First Name: _____ Patient Last Name: _____

Middle Initial: _____ Birth date: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell _____

Phone: _____

Patient Information:

Address: _____ Address 2: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

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

Birth date: _____ E-mail: _____

Emergency contact name and # _____

Employment Status: Full Time Part Time Self Employed Retired Unemployed

How did you hear about our practice? _____

Primary Dental Insurance Information:

Name of policy holder: _____ Relationship to policy holder: _____
 Self Spouse Child Other

Group #: _____ Subscriber ID: _____

Insured Birth date: _____

Employer Name: _____ Insurance Company Name: _____

Ins. Co. Address: _____ City, State, Zip: _____

Secondary Dental Insurance Information:

Name of policy holder: _____ Relationship to policy holder: _____
 Self Spouse Child Other

Group#: _____ Subscriber ID: _____

Insured Birth date: _____

Employer Name: _____ Insurance Company Name: _____

Ins. Co. Address: _____ City, State, Zip _____

PATIENT

SIGNATURE/GUARDIAN _____ DATE _____

MEDICAL HISTORY

PATIENT NAME _____ BIRTH DATE _____

Although dental personnel primarily treat the are 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, please explain: _____

Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____

Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____

Are you taking any medications, pills or drugs? Yes No If yes, please explain: _____

Do you take, or have taken, Phen-Fen or Redux? Yes No _____

Have you ever taken Fosamax, Boniva, Actonel or any Yes No _____

Other medications containing bisphosphonates? _____

Are you on a special diet? Yes No
 Do you use tobacco? Yes No
 Do you use controlled substances? Yes No

Women: Are you
 Pregnant/Trying to get pregnant? Yes No Taking oral Contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?
 Aspirin Penicillin Codeine Local Anesthetic Acrylic Metal Latex Sulfa drugs
 Other: If yes please explain _____

Do you have 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	Yes	No
Breathing Problem	Yes	No	Frequent Headaches	Yes	No	Liver Disease	Yes	No	Disease	Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Low Blood Pressure	Yes	No	Stroke	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Lung Disease	Yes	No	Swelling of Limbs	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Mitral Valve Prolapse	Yes	No	Thyroid Disease	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Osteoporosis	Yes	No	Tonsillitis	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Murmur	Yes	No	Pain in Jaw Joints	Yes	No	Tuberculosis	Yes	No
Congenital Heart Disorder	Yes	No	Heart Pacemaker	Yes	No	Parathyroid Disease	Yes	No	Tumors or Growths	Yes	No
Convulsion	Yes	No	Heart Trouble/Disease	Yes	No	Psychiatric Care	Yes	No	Ulcers	Yes	No
									Venereal Disease	Yes	No
									Yellow Jaundice	Yes	No

Have you ever had any serious illness not listed above? Yes No _____

Comments _____

To the best of my knowledge, the questions on this form have been 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

Date _____



Smile Assessment Questionnaire

NAME _____ DATE _____

1. If there was anything you could change about your smile, what would it be?
2. What is your reason for the appointment?
3. In our work together, what are your goals and objectives?
4. What qualities are you looking for in a dentist?
5. What role does your insurance coverage have in achieving your objectives?
6. What do we need to know about you in order for us to work well together?

Do you like the color of your teeth? Y N

Would you like to change the way your teeth or gums are shaped? Y N

Do you have gaps or spaces between your teeth that you would like filled in? Y N

Are your upper front teeth straight? Y N

Are your lower front teeth straight? Y N

Previous periodontal treatment? Y N

History of smoking: _____

Date of last dental cleaning or exam: _____



DENTAL TREATMENT CONSENT

I am informed and fully understand that inherent in any type of dentistry includes the possibility of unavoidable complications. I am aware that the practice of dentistry is not an exact science. I do not hold Dr. Merissa Richter responsible for any common complications of dentistry. This may include teeth sensitivities, the need for endodontic treatment, TMJ problems, and gingival or mouth tissue sensitivities. I further realize that in spite of the possible complications, my contemplated dental work is desired by me.

I realize that it is mandatory that I give an accurate and complete medical history, and follow all instructions as directed by Dr. Merissa Richter to ensure optimum results from my dental treatment.

The following dental procedures may be included in my treatment plan:

- Dental examination
- Dental x-rays
- Diagnostic photographs
- Prophylaxis
- Fluoride treatment
- Sealants
- Restorative treatment
- Cosmetic treatment
- Periodontal treatment
- Endodontic treatment
- Oral surgery
- Orthodontic

Any questions about my proposed dental treatment have been fully answered. I have read this statement and understand it completely.

Patient/Guardian _____ Signature _____ Date _____

Doctor signature _____ Date _____



Consent for Use and Disclosure of Health Information HIPPA

I, _____, have received and reviewed a copy of Dr. Richter's Dental Office Notice of Privacy Practices and Security Policies and Procedures.

Signature _____ Date _____

Patient Consent Form for Use or Disclosure of Patient's Protected Health Information.

This form must be completed by the individual whose protected health information is to be disclosed or by a parent or guardian if the person is a minor under state law.

Name _____ Date of Birth _____

I hereby authorize Dr. Richter and/or members of her staff to release the following Personal health information:
1) Dental services claims information. 2) Prescriptions, Diagnostic, treatment, and/or care management services. 3) Review required by HHS or HIPAA-compliant health care operations. 4) Communications from the dental office by telephone, email, fax, postal services or any means that the office feels efficient to contact me regarding the above mentioned statements.

My Consent

Effective : Today's Date _____

Continue Indefinitely: I understand that consent may be revoked by me at any time. I understand why I have been asked to disclose this information and am aware that my patients rights are identified in the practice's Notice of Privacy Practices.

Signature of Patient _____ Date _____

Personal Representative _____ Date _____

If there are other persons or entities that you would like us to be able to speak to about your care please list below:

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

OK to leave message containing confidential information on voicemail to this and/or these numbers:

HOME _____ CELL _____

WORK _____



Dental Insurance and You

The Patient Comes First!

You deserve the right care and the right compensation. Dr. Richter's dental treatment plans are tailored to provide you with the needed quality dental care. Dental insurance programs are designed to help with the financial coverage of your dental treatment.

Your Plan's Coverage

Dental benefit plans are an integral part of health care planning. While these plans are made available to employees through companies, unions and associations, each may vary considerably. Your employer, the purchaser of the insurance plan, selects the range of benefits. The insurance plans may provide only limited coverage, or provide coverage of only specific services, such as preventive dental care.

You and your Insurance Plan

Typical criteria and terms espoused by insurance carriers include:

“Reasonable and customary fees”

“Yearly maximums”

“Pre-authorization”

Each of these criteria and terms varies by plan and insurance carrier. To ensure you receive maximum benefits, we recommend that you read your insurance booklet and become familiar with your specific plan requirements. Low reimbursement may be the result of coverage purchased for the insurance plan. If you feel the dental benefits are inadequate, discuss this matter with your employer so that alternatives can be investigated.

You and Your Insurance Claims

We can help. We will process all of your insurance claims expeditiously. Please provide us with your current insurance information when you arrive for your appointment.

Dental Treatment Payment Policy

We require payment at the time of treatment. Your insurance company will send payment directly to you in a timely manner. **Copays will be required for patients with Delta Dental Minnesota Premier plans.**

Dr. Richter is a nonparticipating provider for all insurance companies including Medicare and Medicare Advantage plans. Dr. Richter is a participating provider for Delta Dental Minnesota Premier.

Dr. Merissa Richter and her team take pride in providing comfortable, quality dental care.



FINANCE POLICY

Our commitment is to inform you of the fees for all dental treatment. At your request we will submit pre-estimates to your insurance company when applicable. We also offer affordable payment plans through Care Credit Co. and will make available application forms when needed. The following is our financial policy:

- A. All cosmetic dental appointments will require full payment on the day of the appointment.

- B. Major treatment appointments (crowns, onlays and bridges) will require one-half down at the time of the appointment and balance at completion. **If you have insurance, we will be happy to process your claim and your insurance company will reimburse you directly unless your insurance plan is Delta Dental Minnesota Premier . (See below)**

- C. Preventive treatment appointments (cleanings, exams, x-rays and sealants), restorative appointments (fillings), and periodontal treatment appointments (gum disease, root planing and scaling) will require payment at the time of the visit. **If you have insurance, we will be happy to process your claim and your insurance company will reimburse you directly unless your insurance plan is Delta Dental Minnesota Premier. (See below)**

- D. Method of payment:
 1. Cash, personal checks
 2. Visa, MasterCard, American Express or Discover
 3. Care Credit health card (please inquire with our office manager)

I am aware that Dr. Richter is a non-participating provider for all dental insurance plans including Medicare Advantage Plans. This means that if my dental insurance plan allows me to go out of network to see the dentist of my choice, my out-of-pocket expense will be higher than seeing a participating provider. If you have questions, we ask that you contact your insurance company or your employer. **Dr. Richter is a participating provider for Delta Dental Minnesota Premier. We will ask for your copay at time of appointment and submit the claim for you.**

We ask out of common courtesy that you notify us 24 hours in advance if you need to cancel an appointment or there will be a \$200 charge for our time.

Patient Signature: _____ Date _____



WEST END DENTAL

West End Plaza

1660 S. Hwy 100, Suite 122

Minneapolis, MN 55416

(952) 544-4129

Arriving from the EAST

Take I-94 West to I-394 West.

Exit on Highway 100 South to Cedar Lake Road and follow the curve to the right.

Our office building is the FIRST parking lot on right (across from Podany's Office Furniture) when you exit on Cedar Lake Road.

We are on the ground floor of 1660 West End Plaza.

Arriving from the WEST

Take I-394 East to the Xenia/Park Place Blvd. exit.

Turn south (right) on Park Place Blvd. to Parkdale Drive.

Turn left on Parkdale Drive.

Our office building is the LAST parking lot on the left-hand side, before the entrance onto Highway 100 (across from Podany's Office Furniture).

We are on the ground floor of 1660 West End Plaza.

Arriving from the SOUTH

Take Highway 100 North to the Cedar Lake Road exit (Cedar Lake Road runs parallel to Highway 100 for a short time).

Loop around the Fiat car dealership on the right-hand side and go under Highway 100.

At the stoplight, merge right onto Parkdale Drive.

Our office building is the LAST parking lot on the left-hand side, before the entrance onto Highway 100 (across from Podany's Office Furniture).

We are on the ground floor of 1660 West End Plaza.

Arriving from the NORTH

Take I-694 West to Highway 100 South.

Exit on Cedar Lake Road and curve to the right.

Our office building is the FIRST parking lot on the right (across from Podany's Office Furniture) when exiting Cedar Lake Road.

We are on the ground floor of 1660 West End Plaza.