ROGER R. BARTELS DDS

REGISTRATION & CONSENT

PATIENT INFORMATION- *a copy of driver's license or state issued ID is required to complete your patient file*

Today's Date _____ **Preferred Name/ Nickname** _____

First Name _____ **Last** _____ **Middle** _____

Date of Birth _____ **Gender** M F **SS#** _____ - _____ - _____ **DL#** _____

Street Address _____ **City** _____ **State** _____ **ZIP** _____

Home Phone# (_____)_____ **Cell Phone#** (_____)_____ **Work Phone#** (_____)_____

Email _____

Please circle all that apply: Minor Married Domestic Partner Single Separated Divorced

Employer _____ **Occupation** _____

Employer Address _____ **City** _____ **State** _____ **Zip** _____

Responsible Party to Bill - Spouse or Domestic Partner (Parent or guardian if patient is a minor)

First _____ **Last** _____ **Middle** _____

Date of Birth _____ **Gender** M F **SS#** _____ - _____ - _____ **DL#** _____

Employer _____ **Occupation** _____

Home Phone# (_____)_____ **Cell Phone#** (_____)_____ **Work Phone#** (_____)_____

Emergency *Contact*

Name _____ *Relation to you* _____

Cell Phone# (_____)_____ *Alternate Phone#* (_____)_____

CONSENT FOR SERVICES

I hereby grant complete authority to Roger R. Bartels DDS to administer treatment, such as x-rays, anesthetic and services to perform such dental procedures as may be deemed necessary or advisable in the diagnosis and treatment of my condition.

_____ _____

Signature of Patient, Parent or Guardian Date

_____ _____

Print name or Patient, Parent or Guardian Relationship to Patient

138 Matheson St., Healdsburg, Ca., 95448
707-433-8888
rogerbartelsdds@gmail.com

ROGER R. BARTELS DDS
REGISTRATION & CONSENT

AGREEMENT TO PAY FOR SERVICES

- All services performed must be paid for at time of service unless a financial arrangement has been made in advance.
- Missed or cancelled appointments with less than 24-hour notice are subject to a service charge.
- Overdue accounts are subject to be sent to a third-party collection agency at the discretion of the Doctor.

Patients with Dental Benefits

- As a courtesy, we can submit your dental claims to your primary dental benefit plan. Please provide current and accurate information each time you receive treatment to assure prompt processing of claims.
- All dental benefit information you receive from any source is subject to change by your dental benefit plan at any time.
- No insurance company will guarantee payment until the dental claim has been submitted and processed. All dental services are your financial responsibility and you are responsible for payment in full for any amount not paid by your dental benefit.
- Estimates given of expected dental benefits by this office do not relieve the patient of responsibility to pay for all services.

I have read and understand the above, "Agreement to Pay for Services"

_____ _____

Signature of Patient, Parent or Guardian Date

_____ _____

Print Name of Patient, Parent or Guardian Relation to Patient

RECEIPT OF PRIVACY PRACTICES NOTICE* & THE DENTAL MATERIALS FACT SHEET

I have received a copy of the Notice of Privacy Practices and a copy of Dental Materials Fact Sheet for Roger R. Bartels DDS.

_____ _____

Signature of Patient, Parent or Guardian Date

_____ _____

Print name of Patient, Parent or Guardian Relationship to Patient

*You May Refuse to Sign Acknowledgment of "Notice of Privacy Practices"

OFFICE USE ONLY: We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____Individual refused to sign ____An emergency situation prevented us from obtaining acknowledgement

_____Communications barrier ____Other (specify)_____

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Health History

Date of Birth_____

Patient Name: _____ **Date** _____
First MI Last

Name of Last Dentist seen: _____ **Date of Last Dentist visit:** _____

Medical Dr./Physician's Name: _____ **Date of last Dr./Physician visit:** _____

Preferred Pharmacy: _____ **Tel#** _____ **If Applicable, Kaiser #** _____

Medications:

Are you or have you ever taken any bone altering drugs or any drugs to treat Osteoporosis? ☐ Yes ☐ No

Are you or have you ever taken any of the group of drugs collectively referred to as "fen-phen"? ☐ Yes ☐ No
These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine).

Please list all medications you are taking and for what medical condition:

_____ _____ _____ _____

_____ _____ _____ _____

Allergies—mark all that apply: ☐ Aspirin ☐ Codeine ☐ Iodine ☐ Latex ☐ Local Anesthetic

☐ Penicillin ☐ Sulfa ☐ Other: _____ _____ _____

Please mark 'yes' or 'no' to indicate if you have or have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Skin Rash	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Heart Attack	☐ Yes ☐ No	Special Diet	☐ Yes ☐ No
Arthritis, Rheumatism	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Artificial Heart Valve	☐ Yes ☐ No	Heart Problems	☐ Yes ☐ No	Swollen Feet or Ankles	☐ Yes ☐ No
Artificial Joint	☐ Yes ☐ No	Hepatitis Type ____	☐ Yes ☐ No	Swollen Neck Glands	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Back Problems	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
		Jaw Pain	☐ Yes ☐ No	Tumor or growth on Head or neck	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Ulcer	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Weight Loss, unexplained	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No	Other not listed:	☐ Yes ☐ No
Circulatory Problems	☐ Yes ☐ No	Nervous Problems	☐ Yes ☐ No		
Congenital Heart Lesion	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No		
Cortisone Treatment	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No		
Cough, persistent/ bloody	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No		
Diabetes	☐ Yes ☐ No	Respiratory Disease	☐ Yes ☐ No		
Emphysema	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No		
Epilepsy	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No		
Fainting or dizziness	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No		
Glaucoma	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No		

_____
_____
_____

Women only:

Taking birth control pills? ☐ Yes ☐

No Are you pregnant? ☐ Yes ☐ No

Date due: _____

Are you nursing? ☐ Yes ☐ No

The preceding information about my health and medications is correct to the best of my knowledge.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

_____ _____
Doctor's Signature Date

ROGER R. BARTELS DDS

Dental Insurance

As a courtesy, we will submit your dental claims on your behalf to your dental insurance. It is your responsibility to provide accurate insurance carrier & guarantor information.

- All dental benefit information you receive from any source is subject to change by your dental benefit plan at any time.
- No insurance company will guarantee payment until the dental claim has been submitted, processed and paid.
- All dental services are your financial responsibility and you are responsible for payment in full for any amount not paid by your dental benefit plan.
- Estimates given are not guarantee of payment by the insurance and the patient is responsible to pay for all services.

1) Patient Name _____ D.O.B._____ SS#_____

2) Patient Name _____ D.O.B._____ SS#_____

3) Patient Name _____ D.O.B._____ SS#_____

PRIMARY/ GUARANTOR INFORMATION

Primary Name _____ D.O.B._____ SS#_____

Hm Address_____ City_____ State _____ Zip _____

Home Ph# (_____)_____ Cell Ph# (_____)_____

Name of Dental Insurance_____

Dental insurance member ID # _____ *Grp #*_____

Claim Mailing Address _____ City_____ State _____ Zip_____

Ph# (_____)_____

Assignment of Benefits and Release

I certify that I, and / or my dependent(s), are covered with above named dental insurance company and assign directly to Roger R. Bartels DDS, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Roger R. Bartels DDS, may use/ disclose my health care information to the above named insurance company for the purpose of obtaining payment for services and determining insurance benefits or the benefits for payable for related services.

I have read and understand the above "Assignment of Benefits and Release"

_____ _____

Signature of Primary/ Guarantor Date

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