PATIENT REGISTRATION

Date _____

Patient's Name _____ Sex: M F Birthdate _____
First Middle Last

Please Circle One: Child Single Married Widowed Divorced Separated

Are any immediate family members being seen here: Yes ❑ No ❑

Street Address: _____

City: _____ State: _____ Zip: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ **E-mail:** _____

Patient Employed By: _____ How Long? _____

Patient Social Security #: _____ Drivers License: _____

Name of Person Responsible for this Account: _____

Are you a Full Time Student? Y N If yes college, school & city: _____

If Minor: Mothers Name: _____ Birthdate: _____

Social Security #: _____ Drivers License #: _____

Fathers Name: _____ Birthdate: _____

Social Security #: _____ Drivers License #: _____

EMERGENCY INFORMATION:

Name, Address & Phone of a Relative or Friend not living with you.

_____

_____

Reason for this visit: _____

How did you hear of our office? _____

Dental Insurance Information (Primary Carrier)

Insured's Name: _____ Relationship: _____

Insured's Employer: _____

Insurance Company: _____

Insurance Company's Address: _____

Insurance Phone Number: _____

Social Security #: _____ Birthdate: _____

Group # _____ Insured's I.D. #: _____

Dental Insurance Information (Secondary Carrier)

Insured's Name: _____ Relationship: _____

Insured's Employer: _____

Insurance Company: _____

Insurance Company's Address: _____

Insurance Phone Number: _____

Social Security #: _____ Birthdate: _____

Group # _____ Insured's I.D. #: _____

DENTAL HISTORY

Patient's Name: _____ Birthdate: _____

Check ONLY if YES to any of the following problems that apply.

- ❑ Sensitivity (Hot, Cold, Sweet, Pressure)
  Where? UR LR UL LL
- ❑ Headaches, Earaches, Neck Pain
- ❑ Jaw/Joint Pain
- ❑ Teeth or Fillings Breaking
- ❑ Grinding or Clenching Teeth
- ❑ Bleeding, Swollen, or Irritated Gums
- ❑ Loose, Tipped or Shifting Teeth
- ❑ Bad Breath

Do you have or ever had any of the following:

- ❑ Dentures ❑ Partials
- ❑ Braces ❑ Periodontal Treatments

Dates of Following Treatments:

Last Cleaning _____/_____
Last Oral Cancer Screening _____/_____
Last Complete X-Rays _____/_____

If I could change my smile, I would:

- ❑ Make it Whiter
- ❑ Make it Straighter
- ❑ Close Spaces
- ❑ Replace Silver fillings with Tooth Colored Restorations
- ❑ Repair Chipped Teeth
- ❑ Replace Missing Teeth
- ❑ Replace Old Crowns that Don't Match
- ❑ Have a Smile Makeover

On a scale of 1 - 10, 10 being the highest rating:

How important is your dental health to you?
1 2 3 4 5 6 7 8 9 10
Where would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10
Where do you want your dental health to be?
1 2 3 4 5 6 7 8 9 10

Name of Previous Dentist: _____ Phone: _____

City: _____ State: _____

Why did you leave your Previous Dentist? _____

What is the most important thing to you about your dental visit today? _____

_____

MEDICAL HISTORY

Physician's Name: _____ Last Seen: _____

Physician's Phone Number: _____

Have you had any serious illness or operations? ❑ Yes ❑ No When? _____

If yes, describe _____

Women: Are you Pregnant? ❑ Yes ❑ No If yes, Due Date _____

OB/GYN _____

Nursing? ❑ Yes ❑ No Are you currently taking Birth Control Pills? ❑ Yes ❑ No

Check ONLY if YES to the following:

- ❑ Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)?
- ❑ Do you use Tobacco in any form? If yes, explain what form & how often. _____
- ❑ Do you consume more than (2) alcoholic beverages a day?

Check ONLY if YES to the following:

- ❑ Anemia
- ❑ Arthritis/rheumatism
- ❑ Artificial joints
- ❑ Asthma:
- ❑ Required hospitalization
- ❑ Steroids needed
- ❑ Last episode _____
- ❑ Bleeding abnormally with extractions / surgery
- ❑ Blood disease / clotting disorders
- ❑ Blood thinners
- ❑ Cancer
- ❑ Chemical Dependency
- ❑ Chemotherapy
- ❑ Circulatory problems
- ❑ Cortisone treatments
- ❑ Cough, persistent / bloody
- ❑ Diabetes
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Fainting
- ❑ Glaucoma
- ❑ Headaches
- ❑ High blood pressure

Heart:

- ❑ Artificial heart valve
- ❑ Heart Lesions (congenital)
- ❑ Heart problems
- ❑ Heart surgery
- ❑ Mitral valve prolapsed
- ❑ History of Endocarditis
- ❑ Pacemaker
- ❑ Stroke
- ❑ Hepatitis - type _____
- ❑ Herpes
- ❑ HIV / AIDS
- ❑ HPV (human papilloma virus)
- ❑ Immune deficiency (any)
- ❑ Kidney disease
- ❑ Liver disease
- ❑ Osteoporosis
- ❑ Radiation treatment
- ❑ Respiratory problems
- ❑ Rheumatic fever
- ❑ Scarlet fever
- ❑ Sinus allergies
- ❑ Slow healing wounds
- ❑ Swelling feet / ankles
- ❑ Thyroid problems
- ❑ Tuberculosis
- ❑ Tumors / growths on the head / neck
- ❑ Venereal disease
- ❑ Weight loss, unexplained

Check ONLY if you are ALLERGIC or have ever experienced any reaction to the following?

- ❑ Aspirin
- ❑ Codeine
- ❑ Erythromycin
- ❑ Latex
- ❑ Local anesthetics (novocaine)
- ❑ Motrin
- ❑ Penicillin
- ❑ Sulfa
- ❑ Tetracycline
- ❑ Tylenol

Any other allergies:

_____

_____

_____

_____

List ALL Medications you are currently taking & what they're used for:

_____

_____

_____

_____

Have you Ever taken any of the following medications?

Actonel Aredia Fosamax Reclast Zometa Boniva

Consent:

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have a change in my health or a change in my medication, I will inform the dentist at my next appointment.

The undersigned hereby authorizes Doctor to take x-rays, study models, photographs, or other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatments, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read, understand, and agree to the above terms and conditions.

Signature of Patient

_____ Date _____

(Parent / Guardian if child)

FINANCIAL POLICY

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment. Please note that payment of your bill is considered part of your treatment. Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa and Discover. Outside financing is available upon request and approval.

Please check if you would like more information about financing options. ❑

Please Note: Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance, you will be responsible for any collection and/or legal charges up to 35%.

Do You Have Insurance?

- As a courtesy to you we will help you process your insurance claims. Please understand that we will provide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible.
- All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Our office is not a party to that contract.
- Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.
- We ask that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance company, by cash, check, MasterCard, Visa or Discover at the time we provide the service to you.
- Insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. It payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our financial policy.

Consent:

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO MY DENTAL OFFICE.

I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge and/or attorney fee will be added to any overdue balance.

By signing below, you are authorizing us to call you at any number you provide including calls to mobile/cellular or similar devices for any lawful purpose. You agree to any fees or charges that you may incur for an incoming call from us, and/or outgoing calls to us, to or from any such number, without reimbursement to us.

_____ _____

Patient Signature (parent if child) **Date**