

Patient Registration

Today's Date _____

Last Name _____ First Name _____ MI _____

Date of Birth _____ Age ____ Sex M or F Soc. Sec. # _____

Please Circle One: Single Married Separated Widow

Mailing Address _____ City _____ State _____

Zip Code _____ Email _____

Home Phone (_____) _____ Cell Phone (_____) _____

Driver's License # _____

Employer _____ Work Phone (_____) _____

Occupation _____

Are you a full time student? Yes or No

If patient is a minor: Mother's DOB _____ Father's DOB _____

Name of Parent _____

Parent Soc. Sec. # _____ Parent Employer _____

Parent Phone (_____) _____ Person Responsible for Account _____

Relationship _____

Emergency Contact _____ Relationship _____

Phone # (_____) _____

If you are filling this form out on behalf of another person, what is your relationship to that person?

Name _____

Relationship _____

Reason for today's visit? _____

How did you hear about us?

In-home Mailer Social Media Insurance

Practice Website Internet Family/Friend/Coworker

Other _____

Who can we thank for your visit? _____

Dental Insurance Information (Primary Carrier)

Insured's Name _____

Insured's Employer _____

Insured's DOB _____

Insurance Co _____

Insurance Co Address _____

Insurance Phone # _____

Group # _____ Local # _____

Dental Insurance Information (Primary Carrier)

Insured's Name _____

Insured's Employer _____

Insured's DOB _____

Insurance Co _____

Insurance Co Address _____

Insurance Phone # _____

Group # _____ Local # _____

Dental History

On a scale of 1-10, with 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

What would you like to change about your smile?

- | | | | |
|-----------------------------------|---|--|---------------------------------------|
| <input type="checkbox"/> Color | <input type="checkbox"/> Bite | <input type="checkbox"/> Chipped Teeth | <input type="checkbox"/> Spaces |
| <input type="checkbox"/> Crowding | <input type="checkbox"/> Smile Makeover | <input type="checkbox"/> Missing Teeth | <input type="checkbox"/> Whiter Teeth |

Please share the following dates:

Your last cleaning _____/_____

Your last oral cancer screening _____/_____

Your last complete X-rays _____/_____

What is the most important thing to you about your future smile and dental health? _____

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

Why did you leave your previous dentist? _____

Name of your previous dentist _____

Dental History Cont. - Please mark (x) any of the following conditions that apply to you

Appearance

- Discolored teeth
- Worn teeth
- Misshaped teeth
- Crooked teeth
- Spaces
- Overbite
- Flat teeth

Pain/Discomfort

- Sensitivity (hot, cold, sweet)
- Pressure
- Broken teeth/fillings
- Worn teeth
- Dry Mouth

Function

- Grinding/Clenching
- Headaches
- Jaw Joint (TMJ) pain
- Jaw Joint (TMJ) clicking/popping
- Bad Bite
- Speech Impediment
- Mouth Breathing
- Sore Muscles (neck, shoulders)
- Difficulty Opening or Closing
- Difficulty Chewing on either side

Periodontal (Gum) Health

- Bleeding, Swollen, Irritated gums
- Bad breath
- Loose tipped, shifting teeth
- Previous perio/gum disease

Habits

- Thumb sucking
- Nail-biting
- Cheek/Lip biting
- Chewing on ice/foreign objects

Sleep Pattern or Conditions

- Sleep Apnea
- Snoring
- Daytime Drowsiness
- Bed wetting (for children)

Social

Tobacco
How much _____
How long _____
Alcohol Frequency _____
Drugs Frequency _____

Previous Comfort Options

- Nitrous Oxide
- Oral Sedation (Pill)
- IV Sedation

Please list family history of any conditions marked:

Medical History - Please mark (x) to your response to indicate if you have or have had any of the following

Cancer	Endocrinology	Neurological	Women
Type _____	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Currently Pregnant
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Hepatitis A/B/C	<input type="checkbox"/> Depression	<input type="checkbox"/> Nursing
<input type="checkbox"/> Radiation Therapy	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Dizziness	Medical Allergies
Cardiovascular	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Drug/Alcohol Addic- tion	<input type="checkbox"/> Antibiotics (Penicillin/Amoxicillin / Clindamycin)
<input type="checkbox"/> Angina (chest pain)	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Fainting	<input type="checkbox"/> Opioids (Percocet, Oxycodone, Tylenol 3)
<input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Seizures	<input type="checkbox"/> Latex
<input type="checkbox"/> Heart Conditions	Gastrointestinal	<input type="checkbox"/> Psychiatric Illness	<input type="checkbox"/> Local Anesthetics
<input type="checkbox"/> Heart Surgery	<input type="checkbox"/> Ulcers (Stomach)	Respiratory	<input type="checkbox"/> NSAIDs
<input type="checkbox"/> High/Low Blood Pressure	<input type="checkbox"/> Gastrointestinal Disease	<input type="checkbox"/> Asthma	Other Allergies
<input type="checkbox"/> Mitral Valve Prolapse	Hematologic/Lymphatic	<input type="checkbox"/> Emphysema	<input type="checkbox"/> _____
<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Anemia	<input type="checkbox"/> Respiratory Problems	Additional Comments:
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Blood Disorders	<input type="checkbox"/> Sinus Problems	_____
<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Sleep Apnea	_____
<input type="checkbox"/> Stroke	<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Tuberculosis	_____
	Musculoskeletal	Viral Infections	
	<input type="checkbox"/> Arthritis	<input type="checkbox"/> AIDS	
	<input type="checkbox"/> Artificial Joints	<input type="checkbox"/> HIV Positive	
	<input type="checkbox"/> Jaw Joint Pain	<input type="checkbox"/> HPV	
	<input type="checkbox"/> Rheumatoid Arthritis		

Are you under the care of a physician? Y or N If yes, please explain _____

Physician Name _____ Address: _____ Phone(____) _____

Have you had a serious illness, operation, or hospitalization in the past 5 years? Y or N, If yes please explain.

Are you taking or have you recently taken any prescription or over the counter medicine(s)? Y or N If yes, please list all and why, including vitamins, natural or herbal supplements and/or dietary supplements _____

Have you ever in the past, or are you now currently taking any medications for Osteopenia/Osteoporosis or Bone Disease? If so, please list medications: _____

Have you ever had surgery? If so, what type: _____

Consent:
The undersigned hereby authorizes Doctor to take x-rays, study models, photographs, or any 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 treatment, 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/Legal guardian

Print Name

Date

Dentist Signature

For completion by dentist only | Additional Comments

Financial Policy

Patient Name (print) _____

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 . Payment is due at the time service is provided. Our office accepts cash, personal checks, credit cards and outside patient financing.

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?

- 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.
- As a courtesy to you we will help you process all 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 will determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible. 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. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- 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, credit card or Patient Financing at the time we provide the service to you.
- 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 question 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 from us.

Patient Signature (Parent if child)

Date

Acknowledgement Of Receipt Of Notice Of Privacy Practices

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

**** You may refuse to sign this acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

Patient Name (Printed)

Signature

Date

Authorization To Release Information

Purpose: This form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself.

I, _____, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

Name (Printed)

Relationship

Name (Printed)

Relationship

Name (Printed)

Relationship

For 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

- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (*Please Specify*)

