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 Secondary Coverage

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?

☐ Color ☐ Bite ☐ Chipped Teeth ☐ Spaces ☐ Crowding ☐ Smile Makeover ☐ Missing Teeth ☐ 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

Patient Name (print) ____________________

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

Type ______________

- ☐ Chemotherapy
- ☐ Radiation Therapy

Cardiovascular

- ☐ Angina (chest pain)
- ☐ Artificial Heart Valve
- ☐ Heart Conditions
- ☐ Heart Surgery
- ☐ High/Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke

Endocrinology

- ☐ Diabetes
- ☐ Hepatitis A/B/C
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Thyroid Disease

Gastrointestinal

- ☐ Ulcers (Stomach)
- ☐ Gastrointestinal Disease

Hematologic/Lymphatic

- ☐ Anemia
- ☐ Blood Disorders
- ☐ Bruise Easily
- ☐ Excessive Bleeding

Musculoskeletal

- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Jaw Joint Pain
- ☐ Rheumatoid Arthritis

Neurological

- ☐ Anxiety
- ☐ Depression
- ☐ Dizziness
- ☐ Drug/Alcohol Addiction
- ☐ Fainting
- ☐ Seizures
- ☐ Psychiatric Illness

Respiratory

- ☐ Asthma
- ☐ Emphysema
- ☐ Respiratory Problems
- ☐ Sinus Problems
- ☐ Sleep Apnea
- ☐ Tuberculosis

Viral Infections

- ☐ AIDS
- ☐ HIV Positive
- ☐ HPV

Women

- ☐ Currently Pregnant
- ☐ Nursing

Medical Allergies

- ☐ Antibiotics (Penicillin/Amoxicillin /Clindamycin)
- ☐ Opioids (Percocet, Oxycodone, Tylenol 3)
- ☐ Latex
- ☐ Local Anesthetics
- ☐ NSAIDs

Other Allergies

- ☐ ____________________

Additional Comments:

____
____

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*

Patient Name (print) ______________________

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)*

____

____

____