Patient Registration

Today's Date: _____

Last Name: _____ First Name: _____ MI: _____ DOB: _____ Age: _____

Sex: ○M ○F SSN: _____ Please Circle One: ○Single ○Married ○Separated ○Widow(er)

Mailing Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Phone: _____ Cell: _____

Driver's License #: _____ Employer: _____

Work Phone: _____ Occupation: _____ Full-time student? ○Y ○N

If patient is a minor:

Mother's DOB: _____ Father's DOB: _____ Parent Name: _____

Parent SSN: _____ Employer: _____

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 him/her?

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

Subscriber's Name: _____ Employer: _____

SS #: _____ DOB: ____ /____ /_____ Relationship to Patient: _____

Insurance Company: _____

Ins. Company Address: _____ Ins. Company Phone: _____

Group/Policy #: _____ Member ID: _____

Dental History

When was your last cleaning? _____

Please mark (x) any of the following conditions that apply to you:

Appearance

☐Discolored teeth
☐Worn teeth
☐Misshapen 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/closing
☐Difficulty chewing

Periodontal (Gum) Health

☐Bleeding, swollen Or irritated gums
☐Bad breath
☐Loose, shifting teeth
☐Previous gum disease

Habits

☐Thumb sucking
☐Nail biting
☐Cheek/lip biting
☐Chewing on ice or foreign objects

Sleep Patterns/Conditions

☐Sleep apnea
☐Snoring
☐Daytime drowsiness
☐Bed wetting (for children)

Previous Comfort Options

☐Nitrous oxide
☐Oral sedation (pill)
☐IV sedation

Please list family history of any conditions marked:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Medical History

Patient Name (print): _____

Please mark (x) any of the following conditions that apply to you:

Cancer
Type:
_____
_____
☐ Chemotherapy
☐ Radiation therapy

Cardiovascular disease
☐ Angina (chest pain)
☐ Artificial heart valve
☐ Heart conditions
☐ Heart surgery
☐ High cholesterol
☐ 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 (TMJ) pain
☐ Rheumatoid arthritis

Neurological
☐ Anxiety
☐ Depression
☐ Dizziness
☐ Drug/alcohol addiction
☐ Fainting
☐ Seizures
☐ Psychiatric illness

Respiratory
☐ Asthma
☐ Emphysema
☐ Respiratory problems
☐ Sinus problems
☐ Sleep apnea
☐ Tuberculosis

Social
Tobacco:
How much _____
How long _____
Alcohol frequency:
_____
Drug frequency:
_____

Viral Infections
☐ AIDS
☐ HIV positive
☐ HPV

I am: ☐ Currently pregnant ☐ Nursing

Medical Allergies
☐ Antibiotics (Penicillin/Amoxicillin/Clindamycin)
☐ Opioids (Percocet, Oxycodone, Tylenol 3)
☐ Latex ☐ Local Anesthetics ☐ NSAIDs
☐ Other: _____

Additional Comments: _____

Are you under the care of a physician? ○ Y ○ N

If yes, explain: _____

Physician Name: _____ Address: _____ Phone: _____

Have you had a serious illness, operation, or hospitalization in the past 5 years? ○ Y ○ N

If yes, explain: _____

_____

Have you ever in the past, or are you now currently taking any medication for osteopenia/osteoporosis or bone disease?

○ Y ○ N If yes, please list: _____

Medications

Prescription/Dosage:	Condition:	OTC/Supplement/Vitamins:	Condition:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
	_____		

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*

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 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 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 fees 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

Patient Name (print): _____

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 myself.

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
☐ Communication barriers prohibited obtaining the acknowledgement
☐ An emergency situation prevented us from obtaining acknowledgement
☐ Other: _____
_____
_____

Submit