Patient Registration

Patient Information

Responsible Party ☐ Self ☐ Other ______________________ (Name/Relationship)

First Name: ______________ Last Name: ______________ Middle Initial: _____ Preferred Name: ______________

Address: ______________________ City, State, Zip: ______________________

Home Phone: ______________ Work Phone: ______________ Ext: ____ Cellular: ______________

Birth Date: ______________ Soc Sec: ______________ Driver's Lic: ______________

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

E-mail: ______________________ ☐ I would like to receive correspondences via e-mail.

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired Employer: ______________________

College Student Status: ☐ Full Time ☐ Part Time ☐ Neither School name: ______________________

Preferred Pharmacy: ______________________ Pharmacy number: ______________________

Last Dental visit______________ Reason for today's visit: ______________________

Are you currently experiencing pain? ☐ Yes ☐ No How long have you been in pain? ______________

Dental Concerns? ☐ No ☐ Yes ______________________

Interests/Hobbies: ______________________

Policy Holder ☐ Self ☐ Other ______________________ (Name/Relationship)

Employer: ______________________ Dental Insurance Company: ______________________

Group # ______________________ ID # ______________________

(Complete information below only if patient is not the policy holder.)

First Name: ______________ Last Name: ______________ Middle Initial: ________

Address: ______________________ City, State, Zip: ______________________

Home Phone: ______________ Work Phone: ______________ Ext: ____ Cellular: ______________

Birth Date: ______________ Soc Sec: ______________ Driver's Lic: ______________

How were you referred to our office?

☐ Relative ☐ Friend ☐ Co-worker ☐ Classmate ☐ Teacher Name: ______________________

☐ Money Mailer ☐ Direct Mail Postcard ☐ Insurance List ☐ Signage ☐ Yellow Pages Other: ______________

For Office Use Only

☐ Information updated in computer

MEDICAL HISTORY

PATIENT NAME ______________________________ Birth Date ______________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ○ Yes ○ No If yes, please explain: ____________

Have you ever been hospitalized or had a major operation? ○ Yes ○ No If yes, please explain: ____________

Have you ever had a serious head or neck injury? ○ Yes ○ No If yes, please explain: ____________

Are you taking any medications, pills, or drugs? ○ Yes ○ No If yes, please explain: ____________

Do you take, or have you taken, Phen-Fen or Redux? ○ Yes ○ No ____________

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ○ Yes ○ No ____________

Are you on a special diet? ○ Yes ○ No

Do you use tobacco? ○ Yes ○ No

Do you use controlled substances? ○ Yes ○ No

Women: Are you

Pregnant/Trying to get pregnant? ○ Yes ○ No Taking oral contraceptives? ○ Yes ○ No Nursing? ○ Yes ○ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: ____________

Do you have, or have you had, any of the following?

Condition		Condition		Condition		Condition	
AIDS/HIV Positive	○ Yes ○ No	Cortisone Medicine	○ Yes ○ No	Hemophilia	○ Yes ○ No	Radiation Treatments	○ Yes ○ No
Alzheimer's Disease	○ Yes ○ No	Diabetes	○ Yes ○ No	Hepatitis A	○ Yes ○ No	Recent W eight Loss	○ Yes ○ No
Anaphylaxis	○ Yes ○ No	Drug Addiction	○ Yes ○ No	Hepatitis B or C	○ Yes ○ No	Renal Dialysis	○ Yes ○ No
Anemia	○ Yes ○ No	Easily Winded	○ Yes ○ No	Herpes	○ Yes ○ No	Rheumatic Fever	○ Yes ○ No
Angina	○ Yes ○ No	Emphy sema	○ Yes ○ No	High Blood Pressure	○ Yes ○ No	Rheumatism	○ Yes ○ No
Arthritis/Gout	○ Yes ○ No	Epilepsy or Seizures	○ Yes ○ No	High Cholesterol	○ Yes ○ No	Scarlet Fever	○ Yes ○ No
Artificial Heart Valve	○ Yes ○ No	Excessive Bleeding	○ Yes ○ No	Hives or Rash	○ Yes ○ No	Shingles	○ Yes ○ No
Artificial Joint	○ Yes ○ No	Excessive Thirst	○ Yes ○ No	Hypoglycemia	○ Yes ○ No	Sickle Cell Disease	○ Yes ○ No
Asthma	○ Yes ○ No	Fainting Spells/Dizziness	○ Yes ○ No	Irregular Heartbeat	○ Yes ○ No	Sinus Trouble	○ Yes ○ No
Blood Disease	○ Yes ○ No	Frequent Cough	○ Yes ○ No	Kidney Problems	○ Yes ○ No	Spina Bifida	○ Yes ○ No
Blood Transfusion	○ Yes ○ No	Frequent Diarrhea	○ Yes ○ No	Leukemia	○ Yes ○ No	Stomach/Intestinal Disease	○ Yes ○ No
Breathing Problem	○ Yes ○ No	Frequent Headaches	○ Yes ○ No	Liver Disease	○ Yes ○ No	Stroke	○ Yes ○ No
Bruise Easily	○ Yes ○ No	Genital Herpes	○ Yes ○ No	Low Blood Pressure	○ Yes ○ No	Swelling of Limbs	○ Yes ○ No
Cancer	○ Yes ○ No	Glaucoma	○ Yes ○ No	Lung Disease	○ Yes ○ No	Thy roid Disease	○ Yes ○ No
Chemotherapy	○ Yes ○ No	Hay Fever	○ Yes ○ No	Mitral Valve Prolapse	○ Yes ○ No	Tonsillitis	○ Yes ○ No
Chest Pains	○ Yes ○ No	Heart Attack/Failure	○ Yes ○ No	Osteoporosis	○ Yes ○ No	Tuberculosis	○ Yes ○ No
Cold Sores/Fever Blisters	○ Yes ○ No	Heart Murmur	○ Yes ○ No	Pain in Jaw Joints	○ Yes ○ No	Tumors or Growths	○ Yes ○ No
Congenital Heart Disorder	○ Yes ○ No	Heart Pacemaker	○ Yes ○ No	Parathyroid Disease	○ Yes ○ No	Ulcers	○ Yes ○ No
Convulsions	○ Yes ○ No	Heart Trouble/Disease	○ Yes ○ No	Psy chiatric Care	○ Yes ○ No	Venereal Disease	○ Yes ○ No
						Yellow Jaundice	○ Yes ○ No

Have you ever had any serious illness not listed above? ○ Yes ○ No ____________

Comments: ____________

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To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN ______________________ DATE ____________

OFFICE POLICY

Dental treatment is an excellent investment in an individual's medical and psychological well-being. Financial considerations should not be an obstacle to obtaining this important health service. Being sensitive to the fact that different people have different needs in fulfilling their financial obligations, we are providing the following payment options.

Payment Options:

Payment is due at the time of service. For the convenience of our patients, the following payment options are available:

- **Cash or Check:** A courtesy credit* will be offered for comprehensive treatment plans over $500.00, when paid in full at the initial appointment (*5% with cash or check and 3% with credit card). *A $25.00 fee will be assessed for all returned checks.*
- **Major Credit Cards** We gladly accept Visa, MasterCard, American Express and Discover Credit Cards.
- **Flexible Payment Options** If extensive treatment is recommended, we offer no interest and extended patient payment plans through CareCredit. We assist our patients in the application process.

If you are sent to collections for unpaid account balances, a 35% collections fee will be assessed.

Dental Insurance:

As a **courtesy** to our patients, we are happy to file the forms necessary to see that our patients receive the full benefits of their coverage; however**, we can make no guarantee of any estimated coverage.** Because the insurance policy is an agreement between the patient and their insurance company, we ask that all patients be directly responsible for all charges. If your insurance company does not pay their estimated benefits within 30 days from the date of service, **you are responsible for the entire treatment fee.**

Cancellation Policy:

Our goal is to provide you with quality dental care and personal attention. Your appointment time is reserved *exclusively for you.* If you cannot keep your appointment, please provide 48 hours notice. While we realize there are emergencies, failure to cancel or reschedule an appointment in a timely manner, may result in a cancellation fee of $25 per ½ hour of reserved time.

Acknowledgement:

I hereby acknowledge and agree to the above office policies; accepting full financial responsibility for my dental treatment.

____________________	____________________	____________________
Date	Patient or Responsible Party	Office/Financial Manager

Acknowledgement of Receipt
Notice of Privacy Practices

By signing below I acknowledge that I have received or reviewed the Notice of Privacy, I agree with the terms of this notice and understand my rights under this notice. **By signing below, I consent for the use of my personal health information for treatment, payment, operations, and other uses as described in the privacy notice.** I also understand that I have the right not to sign this agreement.

Name:____

Signature:____

Relationship to Patient:____

Date:____

The information from my health record may be disclosed by the Covered Entity above and provided to the following:

_____________________________ _____________________________

_____________________________ _____________________________

If we are unable to get your acknowledgement, then our office will make a notation as to the reason why it was not obtained.

Reason why acknowledgement was not obtained:

____

Staff Name:____

Signature:____

Date:____