

PATIENT REGISTRATION

Patient number	ABC		
Patient's Name	Sex: M F	Birthdate	Age
Home Address	City	State	Today's Date
Please Circle One: Single, Married, Separated, Widow		Occupation	Home Phone:
Your Employer	How Long Employed	Soc Sec. #	Work Phone:
Are you a full time student? <input type="checkbox"/> Yes <input type="checkbox"/> No	<i>If patient is minor we need:</i>	<i>Mother's Birthdate:</i>	<i>Father's Birth Date</i>
Person responsible for account		Driver's license number	
Name of spouse (Parent if minor)	E-mail:	Cell Phone	
Spouse's (parent's) employer	Spouse's Soc. Sec. #	Work phone	
How did you hear about our office?	EMERGENCY INFORMATION		
Reason for this visit	Name, Address, & telephone of _____ A Relative Not living with you.		

DENTAL INSURANCE INFORMATION (Primary Carrier)			If you have a double digit insurance coverage, complete this for the second coverage		
Insured's name	DOB	SS#	Insured's name	DOB	SS#
Insured's employer			Insured's employer		
Insurance Co			Insurance Co		
Insurance Co Address			Insurance Co Address		
Phone #			Phone #		
Group #	Local #		Group #	Local #	

Emerson Avenue Dental Financial Policy

Thank you for choosing our office as your dental health care provider. We are committed to providing you with the highest quality lifetime dental care, so that you may fully attain optimum oral health. Please understand 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, Care Credit, and Chase Health Advantage. 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 incurred.

DO YOU HAVE INSURANCE?

- 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 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, Care Credit, or Chase Health Advantage 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. If 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.

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.

PATIENT Signature (Parent of Child) _____ Date: _____

DENTAL HISTORY

Please check any of the following problems that apply to you.				Do you smoke or use chewing tobacco? How much? For how long?		
-Sensitivity (hot, cold, sweet) Where? UR LR UL LL	<input type="checkbox"/>			If I could change my smile, I would:		
-Headaches, earaches, neck pain	<input type="checkbox"/>			-Make them whiter	<input type="checkbox"/>	
-Jaw joint pain	<input type="checkbox"/>			-Make them straighter	<input type="checkbox"/>	
-Teeth or fillings breaking	<input type="checkbox"/>			-Close spaces	<input type="checkbox"/>	
-Grinding or clenching teeth	<input type="checkbox"/>			-Replace metal fillings with tooth colored restorations	<input type="checkbox"/>	
-Bleeding, swollen or irritated gums	<input type="checkbox"/>			-Repair chipped teeth	<input type="checkbox"/>	
-Loose, tipped or shifting teeth	<input type="checkbox"/>					
-Bad breath	<input type="checkbox"/>			-Replace missing teeth	<input type="checkbox"/>	
				-Replace old crowns that don't match		
Do you have or have you had any of the following?				-Have a smile makeover	<input type="checkbox"/>	
-Dentures	<input type="checkbox"/>					
-Periodontal (gum) treatments	<input type="checkbox"/>			Comments: _____		
Please share the following dates:				_____		
-Your last cleaning		___ / ___		_____		
-Your last oral cancer screening		___ / ___		_____		
-Your last complete X-Rays		___ / ___		_____		

MEDICAL HISTORY

Please check any of the following that apply to you: (All responses are kept confidential)

<input type="checkbox"/> AIDS/HIV positive	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Jaw Joint Pain	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Allergies (Seasonal)	<input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Sinus Trouble
<input type="checkbox"/> Anemia	<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Stomach Problems
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Fainting	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Stroke
<input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Low Blood Sugar	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Artificial Joints	<input type="checkbox"/> Heart Conditions	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Lesions (Congenital)	<input type="checkbox"/> Nervousness/Depression	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Phen Fen (1 month +)	<input type="checkbox"/> Venereal Diseases
<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Heart Surgery	<input type="checkbox"/> Pregnant Currently	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Pacemaker	<input type="checkbox"/> Psychiatric care	<input type="checkbox"/> Are you taking or have you ever taken Bisphosphonates for osteoporosis (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa)?
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Radiation (head/neck)	
<input type="checkbox"/> Cold Sores/Fever Blisters	<input type="checkbox"/> Hepatitis A, B, or C	<input type="checkbox"/> Renal Dialysis	Women:
<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Respiratory Problems	<input type="checkbox"/> Pregnant/trying
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Taking oral contraceptives
<input type="checkbox"/> Drug Addiction	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Rheumatism	<input type="checkbox"/> Nursing
Do you have any of the following drug allergies?		Are you under a physician's care? Name/Phone	
<input type="checkbox"/> Aspirin	<input type="checkbox"/> Codeine		
<input type="checkbox"/> Darvon	<input type="checkbox"/> Erythromycin	List all medications you take & why	
<input type="checkbox"/> Nitrous Oxide	<input type="checkbox"/> Valium		
<input type="checkbox"/> Metals	<input type="checkbox"/> Penicillin		
<input type="checkbox"/> Local Anesthetic	<input type="checkbox"/> Sulfa		
<input type="checkbox"/> Tetracycline	<input type="checkbox"/> Other		

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 patients) health. It is my responsibility to inform Emerson Avenue Dental of any changes in medical/prescription drug status.

SIGNATURE OF PATIENT, PARENT, GUARDIAN _____ DATE _____

