

# PATIENT REGISTRATION

Patient number ABC

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**Patient's Name** \_\_\_\_\_ Sex: M F Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Today's Date \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

*Please Circle One:* Single, Married, Separated, Widow Occupation \_\_\_\_\_ Home Ph.# \_\_\_\_\_

Your Employer \_\_\_\_\_ How Long Employed \_\_\_\_\_ Your Soc Sec. # \_\_\_\_\_ Work Ph.# \_\_\_\_\_

Are you a full time student?  Yes  No *If patient is minor we need:* Mother's Birthdate \_\_\_\_\_ Father's Birthdate \_\_\_\_\_

Person responsible for account \_\_\_\_\_ Driver's license# \_\_\_\_\_

Name of spouse (Parent if minor) \_\_\_\_\_ E-mail address \_\_\_\_\_ Cell Ph.# \_\_\_\_\_

Spouse's (parent's) employer \_\_\_\_\_ Spouse's Soc. Sec. # \_\_\_\_\_ Work Ph.# \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

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### EMERGENCY INFORMATION

Name, address, & telephone \_\_\_\_\_

Reason for this visit \_\_\_\_\_ of a relative not living with you.

DENTAL INSURANCE INFORMATION (Primary Carrier)	If you have double digit insurance coverage, complete this for the 2nd 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 # _____

## 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 and Discover. 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 up to 35%.

- 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, or Discover 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.

**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. 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 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 or attorney fee will be added to any overdue balance.

Patient Signature (Parent of Child) \_\_\_\_\_ Date: \_\_\_\_\_

# DENTAL HISTORY

Please check any of the following problems that apply to you.

- Sensitivity (hot; cold, sweet)
- Where? UR LR UL LL
- Headaches, earaches, neck pain
- Jaw joint pain
- Teeth or fillings breaking
- Grinding or clenching teeth
- Bleeding, swollen or irritated gums
- Loose, tipped or shifting teeth
- Bad breath
- Do you have or have you had any of the following?
- Dentures
- Partial dentures
- Braces
- Periodontal (gum) treatments

Please share the following dates:

- Your last cleaning \_\_\_\_\_ / \_\_\_\_\_
- Your last oral cancer screening \_\_\_\_\_ / \_\_\_\_\_
- Your last complete X-Rays \_\_\_\_\_ / \_\_\_\_\_

Name of Previous Dentist \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Phone Number \_\_\_\_\_

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? \_\_\_\_\_

- |   |                          |                          |
|---|--------------------------|--------------------------|
|   | Yes                      | No                       |
| If you could whiten your teeth for a cost anyone could afford, would you do it? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you smoke or use chewing tobacco?  | <input type="checkbox"/> | <input type="checkbox"/> |
| How much? _____ For how long? _____   |                          |                          |
| If I could change my smile, I would:  |                          |                          |
| -Make them whiter   | <input type="checkbox"/> |                          |
| -Make them straighter   | <input type="checkbox"/> |                          |
| -Close spaces   | <input type="checkbox"/> |                          |
| -Replace black metal fillings with tooth colored restorations                   | <input type="checkbox"/> |                          |
| -Repair chipped teeth   | <input type="checkbox"/> |                          |
| -Replace missing teeth  | <input type="checkbox"/> |                          |
| -Replace old crowns that don't match  | <input type="checkbox"/> |                          |
| -Have a smile makeover  | <input type="checkbox"/> |                          |

- 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
- Why did you leave your previous dentist? \_\_\_\_\_

# MEDICAL HISTORY

Please check any of the following that apply to you:

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> AIDS                   | <input type="checkbox"/> Dizziness                  | <input type="checkbox"/> HIV Positive           | <input type="checkbox"/> Rheumatism        |
| <input type="checkbox"/> Allergies (Seasonal)   | <input type="checkbox"/> Drug Addiction             | <input type="checkbox"/> Jaundice               | <input type="checkbox"/> Scarlet Fever     |
| <input type="checkbox"/> Anemia                 | <input type="checkbox"/> Emphysema                  | <input type="checkbox"/> Jaw Joint Pain         | <input type="checkbox"/> Seizures          |
| <input type="checkbox"/> Angina (Chest pain)    | <input type="checkbox"/> Excessive Bleeding         | <input type="checkbox"/> Kidney Disease         | <input type="checkbox"/> Stomach Problems  |
| <input type="checkbox"/> Arthritis              | <input type="checkbox"/> Fainting                   | <input type="checkbox"/> Liver Disease          | <input type="checkbox"/> Stroke            |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Glaucoma                   | <input type="checkbox"/> Low Blood Pressure     | <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"/> Pacemaker              | <input type="checkbox"/> Venereal Diseases |
| <input type="checkbox"/> Bruise Easily          | <input type="checkbox"/> Heart Surgery              | <input type="checkbox"/> Phen Fen (1 month +)   | <input type="checkbox"/> Other             |
| <input type="checkbox"/> Cancer                 | <input type="checkbox"/> Hepatitis A                | <input type="checkbox"/> Pregnant Currently     |  |
| <input type="checkbox"/> Chemotherapy           | <input type="checkbox"/> Hepatitis B                | <input type="checkbox"/> Radiation (head/neck)  |  |
| <input type="checkbox"/> Cortisone Medication   | <input type="checkbox"/> Hepatitis C                | <input type="checkbox"/> Respiratory Problems   |  |
| <input type="checkbox"/> Diabetes               | <input type="checkbox"/> High Blood Pressure        | <input type="checkbox"/> Rheumatic Fever        |  |

Do you have any of the following drug allergies?

- |   |                                       |
|---|---------------------------------------|
| <input type="checkbox"/> Aspirin          | <input type="checkbox"/> Codeine      |
| <input type="checkbox"/> Darvon           | <input type="checkbox"/> Erythromycin |
| <input type="checkbox"/> Nitrous Oxide    | <input type="checkbox"/> Valium       |
| <input type="checkbox"/> Percodan         | <input type="checkbox"/> Penicillin   |
| <input type="checkbox"/> Local Anesthetic | <input type="checkbox"/> Sulfa        |
| <input type="checkbox"/> Tetracycline     | <input type="checkbox"/> Latex        |
| <input type="checkbox"/> Other            |                                       |

Are you under a physician's care? What for?  
 \_\_\_\_\_

Are you taking any medications? What?  
 \_\_\_\_\_

Family Physician \_\_\_\_\_

Phone Number \_\_\_\_\_

Patient Signature (Parent of Child) \_\_\_\_\_

Date \_\_\_\_\_

Dentist Signature \_\_\_\_\_

# 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.

\_\_\_\_\_  
{Please Print Name}

\_\_\_\_\_  
{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.

\_\_\_\_\_  
{Please Print Name}

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
{Please Print Name}

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
{Please Print Name}

\_\_\_\_\_  
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)