PATIENT REGISTRATION

Patient number ABC				
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 Phone Number
Your Employer	How Long Employed		Your Soc Sec. #	Work Phone
Are you a full time student? ☐Yes ☐ No	*If patient is minor we need:*		*Mother's Birthdate:*	*Father's Birth Date*
Person responsible for account			Driver's license number	
Name of spouse (Parent if minor)			E-mail address	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 #	

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 and Visa. 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 or Visa 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 offer outside financing through Care Credit and Capital One Healthcare Financing. These companies are not affiliated with our offices and we cannot influence their decisions in approval.
- 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.

It is our office policy to provide you with the full attention of our team. To ensure this is possible, we ask that you arrive on time for and keep your appointments. We request a 48 hour notice if you will not be able to attend your appointment. If you fail two appointments, regretfully we will have to ask you seek treatment elsewhere.

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.				**If you could whiten your teeth for a cost anyone could afford, would you do it?**	☐	
-Sensitivity (hot, cold, sweet) Where? UR LR UL LL	☐			**Do you smoke or use chewing tobacco?** How much? For how long?	☐	
-Headaches, earaches, neck pain	☐			**If I could change my smile, I would:**	☐	
-Jaw joint pain	☐			-Make them whiter	☐	
-Teeth or fillings breaking	☐			-Make them straighter	☐	
-Grinding or clenching teeth	☐			-Close spaces	☐	
-Bleeding, swollen or irritated gums -Loose, tipped or shifting teeth	☐ ☐			-Replace black metal fillings with tooth colored restorations	☐	
-Bad breath	☐			-Repair chipped teeth	☐	
Do you have or have you had any of the following?				-Replace missing teeth -Replace old crowns that don't match	☐ ☐	
-Dentures	☐			-Have a smile makeover	☐	
-Partial dentures	☐			**On a scale of 1 – 10, with 10 being the highest rating:**		
-Braces	☐					
-Periodontal (gum) treatments	☐			-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		
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** _____				**Why did you leave your previous dentist?** _____		
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?** _____		

MEDICAL HISTORY

Please check any of the following that apply to you:

☐ AIDS	☐ Drug Addiction	☐ HIV Positive	☐ Rheumatic Fever
☐ Allergies (Seasonal)	☐ Emphysema	☐ Jaundice	☐ Rheumatism
☐ Anemia	☐ Excessive Bleeding	☐ Jaw Joint Pain	☐ Scarlet Fever
☐ Arthritis	☐ Fainting	☐ Kidney Disease	☐ Seizures
☐ Artificial Heart Valve	☐ Glaucoma	☐ Liver Disease	☐ Stomach Problems
☐ Artificial Joints	☐ Heart Conditions	☐ Low Blood Pressure	☐ Stroke
☐ Asthma	☐ Heart Lesions (Congenital)	☐ Mitral Valve Prolapse	☐ Thyroid Disease
☐ Blood Disease	☐ Heart Murmur	☐ Nervousness/Depression	☐ Tuberculosis
☐ Bruise Easily	☐ Heart Surgery	☐ Pacemaker	☐ Ulcers
☐ Cancer	☐ Hepatitis A	☐ Phen Fen (1 month +)	☐ Venereal Diseases
☐ Chemotherapy	☐ Hepatitis B	☐ Pregnant Currently	☐ Other
☐ Diabetes	☐ Hepatitis C	☐ Radiation (head/neck)	
☐ Dizziness	☐ High Blood Pressure	☐ Respiratory Problems	

Do you have any of the following drug allergies?		**Are you under a physician's care? What for?**
☐ Aspirin	☐Codeine	_____
☐ Darvon	☐ Erythromycin	**Are you taking any medications? What?**
☐ Nitrous Oxide	☐ Valium	_____
☐ Percodan	☐ Penicillin	**Family Physician** **Phone Number**
☐ Local Anesthetic	☐ Sulfa	_____ _____
☐ Tetracycline	☐ Other	

Patient Signature (Parent of Child)		Date		Dentist Signature	