PATIENT REGISTRATION

Patient's Name: _____ Birthdate: _____ Sex: M / F

Is patient under 18 years old? __Yes __No **children under the age of 18 need to be accompanied by a parent or legal guardian**

Name of person responsible for account (if under age 18): _____ Relationship: _____

Patient's Home Address: _____ City: _____ State/Zip_____

Mailing Address (if different from home address): _____City: _____State/Zip_____

Cell # _____ Home # _____ Work # _____

Patient's Employer: _____ Social Security #: _____

Marital Status: Single / Married / Divorced / Widowed

Name of PRIMARY Dental Insurance Info: _____Name of the Insured: _____

Relationship to patient: _____ Insured's Birthday: _____ Insured's Member ID/Social Security: _____

Insured's Employer: _____

Name of SECONDARY Dental Insurance Info: _____Name of the Insured: _____

Relations to the patient: _____ Insured's Birthday: _____ Insured's Member ID/Social Security: _____

Insured's Employer: _____

REGARDING INSURANCE:

- As a courtesy to you we will help you process all your dental insurance claims. Please understand that we will provided 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.
- 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 a co-payment, which is the estimated amount not covered by your insurance company at the time the service is provided 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 my assist in the claim being paid. Our office will not, however, enter into dispute with your insurance company over any claim.

I AUTHORIZE MY INSURANCE COMPANY TO PAY MY BENEFITS DIRECTLY TO MY DENTAL OFFICE and CONSENT TO YOUR USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION TO CARRY OUT PAYMENT ACTIVITIES IN CONNECTION WITH THIS CLAIM.

PATIENT SIGNATURE (Parent/Legal Guardian if child)_____

FINANCIAL POLICY:

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 you to read, agree to, and sign prior to any treatment. Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, Discover, and American Express. Outside financing, Care Credit and Citi Health, is available upon request and approval.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts with a balance exceeding 60 days. In the case it becomes necessary to enlist a collection service and/or legal assistance to collect an unpaid balance, you will be responsible for all collection and/or legal charges that are incurred to collect that balance. 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, prior to treatment, have been made. I further understand that a finance, rebilling, collection charge and/or attorney fee will be added to any overdue balance. Returned checks will be subject to additional fees.
I have read, understand and agree to the above terms and conditions. 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, prior to treatment, have been made. I further understand that a finance, rebilling, collection charge and/or attorney fee will be added to any overdue balance.

Patient Signature (Parent/Legal Guardian if child): _____

Dental History

Patient Name: _____ Birthday: _____

1) **Please share the following dates:**

Your last cleaning: _____
Your last Bitewing X-Rays: _____
Your last Panorex or Full Mouth X-ray: _____

2) **Do you have or have you had any of the following?**

Denture/s: Yes / No Partial Denture/s: Yes / No
Periodontal (gum) treatments: Yes / No Braces: Yes / No

3) Name of Previous Dentist: _____ City/State: _____ Phone number: _____
4) I am changing dentists because: Moved to this area _____Inadequate care _____ Dr. or staff personality, communication problem _____ Fee concern _____

5) Please check any of the following problems that apply to you:	**YES**	**NO**
Sensitivity (hot, cold, sweet, pressure)	___	___
Where? (YOUR: upper left, lower left, upper right, lower right)		
Tooth pain or ache	___	___
Headaches, earaches, neck pain	___	___
Jaw joint pain	___	___
Grinding or clenching teeth	___	___
Teeth or filling breaking	___	___
Bleeding, swollen or irritated gums	___	___
Loose, tipped or shifting teeth	___	___
Bad breath	___	___
Snoring	___	___
Fear of the dentist or treatment	___	___

6) What is the most important thing to you about your dental visit today?
_____
_____

7) If I could change my smile, I would:
Make it whiter _____ Make it Straighter _____
Close Spaces _____ Repair chipped tooth _____
Replace missing teeth _____ Smile Makeover _____

8) I have avoided dental care in the past because of:
Lack of concern_____ Missing work/school time _____
Cost of treatment _____ Trust Factor _____
Fear of: _____

*If more room is needed to write, please use the back of this form.

Medical History

Emergency Contact/s: _____ _____ Phone: _____ Phone: _____

Are you taking any medicines including non-prescription medicines? Yes or No
Please provide us a separate list of all medications (including over the counter) or you may list them:
_____
_____

Are you under a physician's care? What for? _____
Name of Family Physician: _____

Are you allergic to, or have you reacted adversely to any of the following?

___ Aspirin or similar meds
___ Penicillin or other antibiotics
___ Barbiturates, sedatives or sleeping pills
___ Metals of any kind
___ Local anesthetic like Novocain
___ Codeine or similar meds
___ Latex or rubber
___ Other: _____
____ NO KNOWN ALLERGIES

Please check any of the following problems/conditions that you *have or have had a history of*:

____ AIDS/ HIV
____ Allergies (Seasonal)
____ Angina (Chest pain)
____ Arthritis
____ Artificial Valve Replacement
____ Asthma / COPD / Emphysema
____ Bleeding problems
____ Blood Pressure (high / low)
____ Cancer / Tumors
____ Chemotherapy
____ Depression
____ Diabetes
____ Drug Abuse / Alcoholism
____ Eating Disorders, Bulimia, Anorexia
____ Epilepsy / Seizures / MS
____ Glaucoma
____ Heart Attack
____ Heart Infection
____ Heart Surgery
____ Heart Trouble
____ Hepatitis, Jaundice or Liver Disease

____ Hospitalized / Surgical Operation
_____
_____
____ Joint Replacement
How long ago: _____
____ Kidney Trouble
____ Lung Disease
____ Nursing
____ Pacemaker
____Pregnant
How far along: _____
____ Radiation
____ Sinus Problems
____ Sleep Apnea
____ Snoring
____ Stomach Ulcers / Reflux / IBS
____ Stroke
____ Thyroid Problems
____ Tobacco use
OTHER:
_____
_____