



PATIENT REGISTRATION

PATIENT PERSONAL INFORMATION

Last Name _____ First _____ Middle _____
 Birth Date _____ SSN _____ Sex _____ Marital Status _____
 Address _____ City _____ State _____ Zip _____
 Cell # _____ Home # _____ Email _____
 Emergency Contact _____ Emergency Contact Phone # _____
 Referral Type (How did you hear about us?) _____

PERSON RESPONSIBLE/GUARANTOR FOR PAYING BILLS (If self, skip to next section)

Last Name _____ First _____ Middle _____
 Birth Date _____ SSN _____ Sex _____ Marital Status _____
 Address _____ City _____ State _____ Zip _____
 Cell # _____ Home # _____ Email _____

DO YOU HAVE PRIMARY DENTAL INSURANCE ____ Y ____ N

DO YOU HAVE SECONDARY DENTAL INSURANCE ____ Y ____ N

Group No/Name _____
 Insurance Name _____
 Phone # _____
 Employer Name _____
 Subscriber Last, First _____
 Subscriber ID _____ Birth Date _____
 Subscriber SSN _____ (*Required by some insurances)
 Subscriber Address _____
 City _____ State _____ Zip _____
 Relationship to Patient _____

Group No/Name _____
 Insurance Name _____
 Phone # _____
 Employer Name _____
 Subscriber Last, First _____
 Subscriber ID _____ Birth Date _____
 Subscriber SSN _____ (*Required by some insurances)
 Subscriber Address _____
 City _____ State _____ Zip _____
 Relationship to Patient _____

CONSENT

- All new patients will be scheduled for a consultation for their first visit. This consultation includes the oral exam, x-rays, and a treatment plan. Before the comprehensive oral exam of your teeth, gums, and mouth, the doctor will go over your medical history, dental history, and any oral health worries. X-rays and intra-oral pictures will be taken during this appointment. The doctor will not perform the oral exam without radiographs as they allow the doctor to see underneath the gums to detect bone loss, decay, and calculus build-up. This will help the doctor make the proper diagnosis. Recent radiographs can be sent to us from another dental office; however, they must be of diagnostic quality and no more than six months old. Please be aware that a dental CLEANING is not guaranteed the same day as your consultation. We have to determine your dental needs and concerns first, then tailor your hygiene treatment. The consultation concludes with a treatment plan that is tailored to your needs and designed to prevent small issues from getting bigger and more expensive.
- I hereby authorize staff to take X-rays, photographs and any other diagnostic aids deemed appropriate by to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I consent to the use of appropriate medication and therapy as deemed necessary.
- I hereby authorize payment of the dental benefits, otherwise payable to me, directly to the office. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan.
- By signing below, I certify that I read and write English and I have read, fully understand, and agree to the above office policies.

Signature of Patient or Responsible Party _____ **Date** _____

PATIENT MEDICAL INFORMATION

Are you currently under care of a Physician? No Yes If Yes, please explain _____

Have you had any serious illness, operation or been hospitalized? No Yes If Yes, what illness or problem? _____

Have you ever had a serious head or neck injury? No Yes If Yes, please explain _____

Are you currently taking any medication, pills, or drugs? No Yes If Yes, what? _____

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

Have you ever taken the diet control drug Fen-Phen? No Yes

Do you use alcoholic beverages? No Yes

Do you chew / smoke tobacco in any form? No Yes

Do you use controlled substances? No Yes

ARE YOU ALLERGIC TO?

Aspirin	<input type="radio"/> No <input type="radio"/> Yes	Codine	<input type="radio"/> No <input type="radio"/> Yes	Latex Rubber	<input type="radio"/> No <input type="radio"/> Yes
Local Anesthetics	<input type="radio"/> No <input type="radio"/> Yes	Acrylic	<input type="radio"/> No <input type="radio"/> Yes	Metals	<input type="radio"/> No <input type="radio"/> Yes
Penicillin	<input type="radio"/> No <input type="radio"/> Yes	Sulfa Drugs	<input type="radio"/> No <input type="radio"/> Yes	Other	<input type="radio"/> No <input type="radio"/> Yes

WOMEN ONLY: ARE YOU?

Pregnant / Trying to No Yes Taking oral contraceptives No Yes Nursing No Yes

DO YOU HAVE, OR HAD ANY?

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

Anything not mentioned above No Yes

ADDITIONAL COMMENTS _____

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 or Responsible Party _____ Date _____

DENTAL QUESTIONNAIRE

Reason for this visit _____

Date of your last exam _____ Date of your last cleaning _____

Date of your last full series x-rays _____ Date of last cavity detection _____

Name of previous Dentist _____ Phone # _____

How often do you brush your teeth? _____ How often do you floss your teeth? _____

 Is your drinking water fluoridated? No Yes Do your gums bleed while brushing or flossing? No Yes

 Are your teeth sensitive to hot, cold or sweets? No Yes Do you get frequent fever blisters, mouth ulcers, or sores on your lips or in your mouth? No Yes

 Have you ever had burning of the tongue or cracking of the corners of your mouth? No Yes Do you notice popping, clicking or soreness of the jaws or points just in front of the ears? No Yes

 Do you clench or grind your teeth? No Yes Do you wear dentures or partials? If Yes, date of placement? No Yes

 Are you happy with your dentures? No Yes Are you having any specific problems with your teeth, gums, or mouth at this time? No Yes

 Do you have problems with teeth/fillings breaking? No Yes Have you ever had any prolonged bleeding following extractions? No Yes

 Do you have, or have you ever been told, that you have Pyorrhea (Periodontal Disease)? No Yes Do you have difficulty in opening your mouth widely? No Yes

 Do you have an unpleasant taste or odor in your teeth/ mouth? No Yes Does food catch between your teeth? No Yes

ADDITIONAL COMMENTS _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of this office's Notice of Privacy Practices _____

Please Print Name

Signature of Patient or Responsible Party _____ **Date** _____

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
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please specify) _____

OFFICE POLICIES

Thank you for choosing our office as your dental health care provider. We believe that all patients deserve the very best dental care we can provide. Below are the list of our Office Policies which we require that you read and sign prior to any treatment. All patients must complete our Patient Registration forms before seeing the dentist.

Financial Policy

Regarding Insurance:

Your complete insurance information must be presented at the time services are provided. Insurance claims cannot be backdated. Pre-authorization from your insurance may be required before any work can be done to protect you from unexpected payment responsibilities. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. Dental insurance is not meant to be a "pay-all" it is only meant to be an aid. Office will file claim on your behalf a maximum of two times as a courtesy. After which patient will be billed and may request a copy of the claim to submit manually. If you have any questions regarding your coverage, you should contact your insurance carrier. It's your responsibility to know your coverage. We make every effort to provide for you an accurate estimate with the information you and your insurance provides us. Please be aware that your patient responsibility estimates are only an approximation and may change as we acquire more information from your insurance. Insurance co-pays and deductibles must be paid at the time of service. If for any reason your insurance does not pay its expected portion for a completed procedure, that balance will become the responsibility of the patient a statement of balance due will be generated and sent to you. Please be aware that the process of insurance billing and auditing of patient account may occur sometime after your date of service. We always strive to ensure all insurance payment information and patient responsibilities are correct. All invoices are due and payable within 30 days of service. Interest will be charged on past due invoices at the rate of 1.5% per month (18% per annum). In the event it becomes necessary to turn your account(s) over to a collection agency or use an attorney, the responsible party promises to pay, in addition to the amount due, all costs of collection, court costs, and reasonable attorney fees.

Regarding Payment:

We accept the following forms of payment: Cash, Check, Money Order, Visa, Mastercard, Discover, American Express, and Care Credit. All returned checks will be subject to a \$25.00 returned check fee. This fee covers the processing fees our office incurs. Payment in full is due at the time services are rendered unless an agreement has been reached in writing between the office and the patient. For major work (dentures, partials, crown, etc.), a 50% deposit is required to start the procedure and the remaining balance will be due upon delivery.

Refund Policy:

You may discontinue treatment and request a refund at any time. We will refund any amount paid for treatment that you did not receive. Please be aware that after the treatment is completed, it is non-refundable. This includes, but is not limited to initial services such as exams, radiographs, cleanings, etc. All refunds will be processed back to the original form of payment, except cash payments which will be refunded by check. All refund requests, cash or credit card may take up to 15 business days to process. Any refund of payment originated through third party lenders must be refunded to the original account. Please contact the third-party lender for more information regarding their refund policy as processing of refunds may not be reflected on an account for up to 2 billing cycles. Refunds for prosthetics (Dentures, partial dentures, crowns, etc.) and appliances (night guards, clear aligners, retainers, space maintainers, etc.) are available however, all fees are built into the prices of the prosthetics or appliance. These fees include the material fees, the lab fees, the labor fees, and the shipping fees. All lab fees are included in the price of any prosthetic, however, if you choose to discontinue the treatment, the lab fee will still be charged to your account.

No-Show Policy

Our office defines a "No-show" appointment as any scheduled appointment in which the patient either: Does not arrive to the appointment; Cancels with less than 24 hours' notice; Arrives more than 10 minutes late and is consequently unable to be seen.

Impact of a "No-Show" Appointment:

"No-show" appointments have a significant negative impact on our practice and the care we provide to our patients. When a patient "no-show" a scheduled appointment it potentially jeopardizes the health of the "no-showing" patient. It is unfair (and frustrating) to other patients that would have taken the appointment slot and disrespects not only the provider's time, but also the time of the entire clinic staff.

How to Avoid Getting a "No-Show":

Appointment Confirmation

We will attempt to contact you one business day and two hours before your scheduled appointment to confirm your visit. If we are unable to speak with you and must leave a message, you will need to contact office before the appointment, otherwise the appointment will be canceled and marked as a "no-show".

Always Arrive 5-10 Minutes Early

When you schedule an office visit with us, we expect you to arrive at our practice 5-10 minutes prior to your scheduled visit. This allows time for you and our staff to address any insurance or billing questions and/or to complete any necessary paperwork before the scheduled visit.

Give 24 Hours' Notice if You Need to Cancel

When you need to cancel or rebook a scheduled visit, we expect you to contact our office no later than 24 hours before the scheduled visit. This allows us a reasonable amount of time to determine the most appropriate way to reschedule your care as well as giving us the opportunity to rebook the now vacant appointment slot with another patient. If it is less than 24 hours before your appointment and something comes up, please give us the courtesy of a phone call.

Consequences of "No-Show" Appointments

- If you miss 3 or more appointments within 90 days, you may be dismissed from the clinic.
- Patient dismissal is at the discretion of your dental provider and the practice manager.
- If you are dismissed from the clinic, your remaining scheduled appointments will be cancelled.
- Only emergency dental treatment will be offered within the first 30 days of dismissal.
- Reapplication to the clinic after a six-month period after initial dismissal letter will be considered by your dental provider and the practice manager.

By signing below, I certify that I read and write English and I have read, fully understand, and agree to the above office policies.

Signature of Patient or Responsible Party _____ **Date** _____