



## Registration Information

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Patient Name: \_\_\_\_\_

Last

First

Middle

Male \_\_\_ Female \_\_\_ Married \_\_\_ Single \_\_\_ Child \_\_\_ Other \_\_\_

Social Security # \_\_\_\_\_ Birth Date \_\_\_\_\_ Driver License # \_\_\_\_\_

Phone (H)# \_\_\_\_\_ Work # \_\_\_\_\_ Ext.# \_\_\_\_\_ Cell # \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ Would you like text/email reminders Yes \_\_\_ No \_\_\_

Home Address \_\_\_\_\_

Employer Name: \_\_\_\_\_ Emergency Contact Name and Phone: \_\_\_\_\_

## Referral Information

Can we thank someone for referring you?

Or did you find us on your own?

Family member \_\_\_\_\_

\_\_\_ Website

Coworker \_\_\_\_\_

\_\_\_ Yellow Pages

Friend \_\_\_\_\_

\_\_\_ Internet

Doctor \_\_\_\_\_

\_\_\_ Other

We love referrals! For each adult referral you send to us, we will send you a gift as our way of saying thank you! Refer 3 patients in a year and you will reach VIP status!

(Does not include referrals of immediate family members.)

Appointment Policy: We require 48-hour notice for appointment cancelations. Appointment

Changes with out adequate notice may be subject to a fee of up to \$50.00, payable by patient and not the insurance company.

## Insurance Information

### Primary Insurance Policy

Name of Policy Holder: \_\_\_\_\_ Is the Policy Holder a patient?  Yes  No

Policy Holder's Date of Birth: \_\_\_\_\_ Policy Holder's ID# \_\_\_\_\_ Group # \_\_\_\_\_

Policy Holder's Employer: \_\_\_\_\_ Patient's relationship to the Policy Holder:  Self  Spouse  Child  Other \_\_\_\_\_

Dental Insurance Company Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

### Secondary Insurance Policy

Name of Policy Holder: \_\_\_\_\_ Is the Policy Holder a patient?  Yes  No

Policy Holder's Date of Birth: \_\_\_\_\_ Policy Holder's ID# \_\_\_\_\_ Group # \_\_\_\_\_

Policy Holder's Employer: \_\_\_\_\_ Patient's relationship to the Policy Holder:  Self  Spouse  Child  Other \_\_\_\_\_

Dental Insurance Company Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Please be aware that we collect estimated insurance portions at each visit. Your insurance policy is a contract between you and your insurance company. You are responsible for any unpaid balances, regardless of the original estimate of insurance benefit. As a courtesy to you we will file your claims with your insurance company. Insurance payments are normally received within 30 to 45 days. Any unpaid balances after 60 days are your responsibility and are due at that time. All deductibles and co-payments are due at the time of service. A completed claim form or copy of your insurance card will need to be kept on file in our office. We try to answer any questions you may have about your insurance company, however you may need to contact your insurance company for additional information. If your insurance changes, it is your responsibility to provide updated information to our office.

**Assignment of Benefit:** Please read and sign to have our office file your insurance: I authorize the release of information and understand that I am responsible for all costs of dental treatment. I hereby authorize payment directly to \_\_\_\_\_ of the insurance benefits otherwise payable to me.

**X Signature of patient, parent or guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## Billing Policy, Consent for Treatment and Payment

Payment is expected at time of service. We accept cash, check, Visa, Discover, MasterCard and CareCredit. Returned checks are subject to a \$25.00 fee. Aged balances over 60 days, regardless of insurance, are subject to a billing charge of \$2.00 per month and/or finance charges of 21.0% A.P.R. Balances not paid within ten days of the due date are subject to a late fee of 5% or \$15.00 per service date. A past due balance is any amount owing from a prior visit where an insurance payment has not been received by us within 60 days. If you have a past due balance and wish to receive service, you will be required to pay the past due balance and the new charges at time of service.

### FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT:

I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I agree to pay all charges for and by members of my family shown by statements, promptly upon presentation thereof. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within 30 days of billing date. In event legal action should become necessary to collect an unpaid balance due for medical services rendered to my family or me I/we agree to pay reasonable attorney's fees or other such costs as the Court determines proper. It is agreed that all payments will not be delayed or withheld because of any insurance coverage or the pendency of claims thereon, and all proceeds of insurance are assigned to this office where applicable, but without their assuming responsibility for the collection thereof. (A copy of this assignment is as valid as the original.) NOTICE: Do not sign this agreement before you read and agree to the conditions set forth. You are entitled to a copy of this agreement at the time you sign. Keep it to protect your legal rights.

**AGREEMENT:** The above information is for the purpose of obtaining credit and is warranted to be true. I authorize the creditor or his agent to make a credit investigation, including employment verification. I hereby acknowledge receipt of a copy of this form.

**X Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## Acknowledgement of receipt of Notice of Privacy Practices (HIPAA)

You may refuse to sign this acknowledgement.

I, \_\_\_\_\_, have received a copy of this office's Notice of Privacy Practices and consent to the healthcare operations it describes.

Print the Name of the Patient or Personal Representative: \_\_\_\_\_

**X Signature of Patient or Personal Representative:** \_\_\_\_\_ **Relationship to Patient:** \_\_\_\_\_

# MEDICAL HISTORY

PATIENT NAME \_\_\_\_\_ Birth Date \_\_\_\_\_

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now?  Yes  No If yes, please explain: \_\_\_\_\_
- Have you ever been hospitalized or had a major operation?  Yes  No If yes, please explain: \_\_\_\_\_
- Have you ever had a serious head or neck injury?  Yes  No If yes, please explain: \_\_\_\_\_
- Are you taking any medications, pills, or drugs?  Yes  No If yes, please explain: \_\_\_\_\_
- Do you take, or have you taken, Phen-Fen or Redux?  Yes  No \_\_\_\_\_
- Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?  Yes  No \_\_\_\_\_
- Are you on a special diet?  Yes  No
- Do you use tobacco?  Yes  No
- Do you use controlled substances?  Yes  No

Women: Are you \_\_\_\_\_

Pregnant/Trying to get pregnant?  Yes  No Taking oral contraceptives?  Yes  No Nursing?  Yes  No

Are you allergic to any of the following?

- Aspirin  Penicillin  Codeine  Local Anesthetics  Acrylic  Metal  Latex  Sulfa drugs
- Other If yes, please explain: \_\_\_\_\_

Do you have, or have you had, any of the following?

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

Have you ever had any serious illness not listed above?  Yes  No

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, PARENT, or GUARDIAN \_\_\_\_\_

DATE \_\_\_\_\_