

PATIENT REGISTRATION

PLEASE PRINT CLEARLY

Today's Date: _____

Patient's Information

LAST Name: _____

Social Security Number: _____

FIRST Name: _____ MI: _____

Birth Date: _____

Title: Mr. Mrs. Ms. Dr. Gender: M F

Driver's License #: _____

Preferred Name: _____

Family Status: Married Single Child Other

Address: _____

Email Address: _____

I would like to receive correspondences via e-mail.

City: _____

Emergency Contact Name: _____

State: _____ Zip Code: _____

Relationship to Patient: _____

Home Phone: _____

Emergency Contact Phone: _____

Cell Phone: _____

Emergency Contact Alternate Phone: _____

Work Phone: _____ Ext _____

Other Phone: _____

Patient's Employer

Name: _____

Occupation: _____

Address: _____

Years with Current Employer: _____

City: _____

Are you a full-time student? Yes No

State: _____ Zip Code: _____

If Yes, School Attending: _____

Responsible Party/Insurance Policy Holder (if different than the patient)

Last Name: _____

Social Security Number: _____

First Name: _____ MI: _____

Birth Date: _____

Title: Mr. Mrs. Ms. Dr. Gender: M F

Driver's License #: _____

Preferred Name: _____

Family Status: Married Single Child Other

Address: _____

Email Address: _____

I would like to receive correspondences via e-mail.

City: _____

Responsible Party is also a Policy Holder for Patient

State: _____ Zip Code: _____

Primary Insurance Policy Holder

Home Phone: _____

Secondary Insurance Policy Holder

Cell Phone: _____

Work Phone: _____ Ext _____

Other Phone: _____

Responsible Party/Insurance Policy Holder's Employer (if different than the patient)

Name: _____

Occupation: _____

Address: _____

Years with Current Employer: _____

City: _____

State: _____ Zip Code: _____

Whom may we thank for referring you to our practice?

- Newspaper _____ Magazine _____ Website _____
Family/ Friend _____ Other Doctor _____ Yellow Pages _____
Other _____ Insurance Company _____

INSURANCE INFORMATION

PATIENT NAME: _____

TODAY'S DATE: _____

Primary Dental Insurance Information

Policy Holder's Name: _____
Policy Holder's Date of Birth: _____
Patient's Name: _____
Patient's Date of Birth: _____
Group Plan Name: _____
Employer: _____
ID Number: _____
Policy #/Plan/Group ID: _____

Relationship to Patient: Self Spouse Parent Other
Insurance Company: _____
Insurance Phone Number: _____
Insurance Address: _____
City: _____
State: _____ Zip Code: _____

Secondary Dental Insurance Information

Policy Holder's Name: _____
Policy Holder's Date of Birth: _____
Patient's Name: _____
Patient's Date of Birth: _____
Group Plan Name: _____
Employer: _____
ID Number: _____
Policy #/Plan/Group ID: _____

Relationship to Patient: Self Spouse Parent Other
Insurance Company: _____
Insurance Phone Number: _____
Insurance Address: _____
City: _____
State: _____ Zip Code: _____

Primary Medical Insurance Information

Policy Holder's Name: _____
Policy Holder's Date of Birth: _____
Patient's Name: _____
Patient's Date of Birth: _____
Group Plan Name: _____
Employer: _____
ID Number: _____
Policy #/Plan/Group ID: _____

Relationship to Patient: Self Spouse Parent Other
Insurance Company: _____
Insurance Phone Number: _____
Insurance Address: _____
City: _____
State: _____ Zip Code: _____

Secondary Medical Insurance Information

Policy Holder's Name: _____
Policy Holder's Date of Birth: _____
Patient's Name: _____
Patient's Date of Birth: _____
Group Plan Name: _____
Employer: _____
ID Number: _____
Policy #/Plan/Group ID: _____

Relationship to Patient: Self Spouse Parent Other
Insurance Company: _____
Insurance Phone Number: _____
Insurance Address: _____
City: _____
State: _____ Zip Code: _____

I authorize my insurance company to directly pay my dental office all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize my dental office to release all necessary information to secure the payment of benefits.

Name

Relationship to Patient

Signature

Date

MEDICAL/DENTAL HISTORY

PATIENT NAME: _____

The following information is essential for this office to provide dental care in a manner that is compatible with your general health. Your cooperation in providing accurate information is necessary to meet your dental needs safely and efficiently. Incorrect information can be dangerous to your health.

Primary Physician

Name: _____

Address: _____

City: _____

State: _____ Zip Code: _____

Phone Number: _____

Fax Number: _____

Specialist Physician (Cardiologist, Endocrinologist, ect)

Name: _____

Address: _____

City: _____

State: _____ Zip Code: _____

Phone Number: _____

Fax Number: _____

ALL QUESTIONS MUST BE ANSWERED.

1. Are you generally in good health? _____
2. How many hours has it been since you had anything to eat or drink? _____
3. When was your last physical examination? _____
4. Are you currently under the care of a physician? _____
 - a. If yes, for what reason or condition? _____
5. Have you been hospitalized, had a major operation or had a serious illness within the last 5 years? _____
 - a. If yes, for what reason or condition? _____
6. Are you currently taking any medications? _____
 - a. If yes, please list. _____
7. Are you currently taking any herbal supplements or vitamins? _____
 - a. If yes, please list. _____
8. Are you or have you ever taken Bisphosphonate drugs for osteoporosis such as Fosomax, Actenol, Boniva, Ridrocal, Zometa, Aredia, Skelid? _____
 - a. If yes, for how long? _____
9. Have you ever had an unusual or allergic reaction to an anesthetic or drug such as penicillin, codeine, aspirin, erythromycin, tetracycline, epinephrine or any other drugs? _____
 - a. If so, what drugs or medication? _____
10. Have you ever had an unusual or allergic reaction to any dental materials or latex? _____
 - a. If yes, what materials? _____

PROFESSIONAL
NOTES

11. Have you ever had complications during or following dental treatment? _____
a. If yes, describe. _____
12. Do you wear contact lenses? _____
13. Do you have difficulties hearing? _____
14. Do you smoke or use any tobacco products? _____
a. If yes, what type of tobacco products? _____
b. For how long and how frequently? _____
15. Have you had a joint replacement such as hip, knee, or shoulder? _____
a. If yes, when? _____
16. Have you ever been told you needed to take an antibiotic before dental treatment? _____
a. If yes, why and what medication were you told to take? _____

HAVE YOU EVER HAD OR BEEN TREATED FOR:

17. Rheumatic fever, rheumatic heart disease, heart murmur, congenital heart disease, heart valve replacement or mitral valve prolapse? _____
a. If yes, what? _____
18. Heart trouble, heart attack, angina, heart surgery, a pacemaker or an irregular heart beat? _____
a. If yes, what? _____
19. Abnormal blood pressure? (high or low pressure) _____
20. Bleeding problems such as hemophilia, Von Willebrand's disease, sickle cell anemia, or leukemia? _____
a. If yes, what? _____
21. Blood disorders such as anemia? _____
a. If yes, what? _____
22. Bone disorders such as osteoporosis, Paget's disease of bone or multiple myeloma? _____
a. If yes, what? _____
23. A stroke, convulsions, fainting, seizures or epilepsy? _____
a. If yes, what? _____
24. Cancer, x-ray treatments, radiation treatments or chemotherapy? _____
a. If yes, what? _____
25. Tumors or growths? _____
26. Diabetes? _____
27. Liver disease, hepatitis, or jaundice? _____
a. If yes, what? _____
28. Blood transfusion? _____
a. If so, when? _____
29. Breathing problems, asthma, tuberculosis, lung disease, hay fever or any other respiratory disease? _____
a. If yes, what? _____
30. Kidney problems or renal disease? _____
31. Thyroid disease? _____
32. Glaucoma? _____
33. Stomach, intestinal disease, ulcers or colitis? _____
34. HIV, herpes, hepatitis or venereal disease? _____
35. Alzheimer's disease, dementia or memory problems? _____
a. If yes, what? _____

- 36. Have you ever had a serious injury to your head or neck? _____
 a. If yes, describe. _____
- 37. Do you have any history of sinus problems? _____
 a. If yes, describe. _____
- 38. Have you taken any cortisone or steroids during the past year? _____
 a. If yes, describe. _____
- 39. Have you consulted with or been treated by a psychiatrist, psychologist or counselor? _____

- 40. Have you ever been treated for drug or alcohol addiction? _____

PROFESSIONAL
NOTES

For Women:
 41. Are you pregnant? _____
 42. Are you taking any contraceptives? _____

- 43. Do you grind your teeth or clench your jaw? _____
- 44. Do you have pain in the jaw joint or around the ears? _____
- 45. Do you have a temporomandibular joint (TMJ) problem? _____
- 46. When was your last dental visit? _____
- 47. What was the reason for your last visit? _____
- 48. Do you have any of your x-rays or dental records? _____
- 49. Do you like your smile? _____
- 50. How can we help you today? _____

- 51. Is there anything you wish to discuss with the doctor in private? _____

- 52. Do you have any disease, condition, or problem not listed above that we should know about?

 a. If yes, describe. _____

I have reviewed and understand the information on this questionnaire and certify the information I have provided is accurate and complete. I understand that this information will be used by my dental office to help determine appropriate and healthful dental treatment. If there are any changes in my medical status or condition, I will inform my dental office. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist or any other member of the staff responsible for any errors or omissions that I may have made in the completion of this form. Since at each visit a treatment plan will be presented and the work to be done is explained to me before treatment is begun, I give my dental office my consent to perform any needed dental treatment.

I understand that I am financially responsible for all charges whether covered or not covered or denied by my insurance company. I also understand that, even with or without insurance coverage, I am responsible for any charges that are incurred for any treatment rendered.

Name

Relationship to Patient

Signature

Date

Doctor's Signature

Date

OFFICE POLICY

PATIENT PRIVACY

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment or health care options.

As our patient, we want you to know that we respect the privacy of your personal dental records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal dental records. We may have indirect treatment relationships with you (such as laboratories that only interact with doctors and not patients), and may have to disclose personal health information for purposes of treatment, payment or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke any actions that have already been taken which relied on this or a previously signed consent. If you have any objection to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

FINANCIAL POLICY

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment. In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment.

All emergency dental services or any dental services performed without previous financial arrangements must be paid for in full at the time services are performed unless other arrangements are made. Deductibles and co-payments are due at the time of treatment.

We are pleased to be a provider for many insurance carriers and will work with dental insurance companies to maximize your benefits and directly bill them for reimbursement for your treatment. I authorize my insurance company to directly pay my dental office all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize my dental office to release all necessary information to secure the payment of benefits.

I understand that I am fully financially responsible for ALL charges whether covered or not covered or denied by my insurance company. I also understand that, even with or without insurance coverage, I am responsible for any charges that are incurred for any treatment rendered.

If the insurance company does not pay your balance within 30 days, we will ask that you contact the carrier to help speed things up.

A fee of \$50 is charged for patients who miss or cancel more than two times in one calendar year without twenty-four hour notice. A fee of \$25 will be charged for returned checks. Balances older than 90 days may be subject to additional collection fees and interest charges.

Payment options include: cash, check, Visa, MasterCard, Discover, and American Express in addition to financing options if qualified.

OFFICE POLICY (CONTINUED)

PATIENT CARE

We believe that an informed patient ends up as a happy patient. Many of the procedures in dentistry are complex and take multiple appointments, some of which may be lengthy in time. Also, due to the laboratory procedures involved, there may be weeks in between visits when no treatment is rendered. It is our goal to satisfy both the cosmetic and functional needs for our patients. While we will always do our best to please our patients, no one is as good as nature.

When fabricating dentures it should be remembered that each set is different due to the ever changing bone level and soft tissue of each patient. A wax try in (trial denture) will be made and the patient will be able to evaluate and make changes at this stage if necessary. Once accepted and completed, no changes can be made in the final denture without the patient incurring an additional fee. Also, after a period of time, it will become necessary to reline dentures to accommodate their fit.

While crown and bridge porcelain restorations most resemble natural teeth, there still may be some compromises in their fabrication. Also, during the lifetime of any restoration it may be necessary to repair or modify this restoration due to breakage or normal wear.

The utilization of gold collars or gold biting surfaces, the number of missing teeth, periodontal treatment, the incorporation of implants, and other factors may lead to compromises in case design. Therefore, ideal esthetics and function may be altered in an attempt to save a patient's teeth. Also, when removing existing crown and bridge, a treatment plan may be subject to change as it is not always possible to determine the health of a tooth under an existing crown. The utilization of a build up material may be necessary to reconstruct a tooth during a crown appointment to gain more strength.

It should be noted that case success is dependent on many things, some of which include, patient health, patient resistance, home care and keeping up with maintenance visits. A designed hygiene recall program including examination and films must be followed and maintained. It is the responsibility of the patient if dental health is to be insured. The practice of dentistry is not an exact science and no guarantee can be made especially when dealing with healing and the other factors previously mentioned. When utilizing implants, case success is always dependent on the implant success.

It should be stated that during treatment or in the future, it may be necessary to refer a patient to other dental specialists such as an endodontist, periodontist, or oral surgeon. This additional cost is not included in our restorative fee.

I have reviewed, understand and agree to the office policies including patient privacy, financial policy and patient care.

Name

Relationship to Patient

Signature

Date

Doctor's Signature

Date