

PATIENT REGISTRATION

Patient's Name	Birthdate	Age	Today's Date
Home Address	City	State	Zip
Home Phone	Cell Phone	Work Phone	
Email Address:			
Please Circle One: Single, Married, Separated, Widow		Your Soc Sec. #	
Your Employer	How Long Employed	Occupation	
Are you a full time student? <input type="checkbox"/> Yes <input type="checkbox"/> No		If patient is minor we need: Mother's Birthdate:	Father's Birth Date
Person responsible for account <input type="checkbox"/> Check if listed above		EMERGENCY INFORMATION	
Name		Name, Address, & phone of a relative not living with you	
Address			
Phone	SSN		
How did you hear about our office?		Reason for this visit	

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's name	DOB	SS#
Insured's employer	Insurance Co	Group Number

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, Visa, American Express, and Discover. 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, Visa or Discover 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 are committed to seeing you on time, and ask that you value our time as well. If there are any changes to your appointment time, we ask that you inform us at least 48 hours in advance.

Appointments cancelled within 48 hours may incur \$75 cancellation fee.

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.

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?	<input type="checkbox"/>	
-Sensitivity (hot, cold, sweet) Where? UR LR UL LL	<input type="checkbox"/>		Do you smoke or use chewing tobacco? How much? For how long?	<input type="checkbox"/>	
-Headaches, earaches, neck pain	<input type="checkbox"/>		If I could change my smile, I would:	<input type="checkbox"/>	
-Jaw joint pain	<input type="checkbox"/>		-Make them whiter	<input type="checkbox"/>	
-Teeth or fillings breaking	<input type="checkbox"/>		-Make them straighter	<input type="checkbox"/>	
-Grinding or clenching teeth	<input type="checkbox"/>		-Close spaces	<input type="checkbox"/>	
-Bleeding, swollen or irritated gums	<input type="checkbox"/>		-Replace black metal fillings with tooth colored restorations	<input type="checkbox"/>	
-Loose, tipped or shifting teeth	<input type="checkbox"/>		-Repair chipped teeth	<input type="checkbox"/>	
-Bad breath	<input type="checkbox"/>		-Replace missing teeth	<input type="checkbox"/>	
Do you have or have you had any of the following?			-Replace old crowns that don't match	<input type="checkbox"/>	
-Dentures	<input type="checkbox"/>		-Have a smile makeover	<input type="checkbox"/>	
-Partial dentures	<input type="checkbox"/>		On a scale of 1 – 10, with 10 being the highest rating:		
-Braces	<input type="checkbox"/>				
-Periodontal (gum) treatments	<input type="checkbox"/>		-How important is your dental health to you? 1 2 3 4 5 6 7 8 9 10		
Please share the following dates:			-Where would you rate your current dental health? 1 2 3 4 5 6 7 8 9 10		
-Your last cleaning	___ / ___		-Where do you want your dental health to be?		
-Your last oral cancer screening	___ / ___				
-Your last complete X-Rays	___ / ___				
Name of Previous Dentist			1 2 3 4 5 6 7 8 9 10		
City _____ State _____			Why did you leave your previous dentist?		
Phone Number _____			_____		
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:

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

Do you have any of the following drug allergies?

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Codeine	Are you under a physician's care? What for?
<input type="checkbox"/> Darvon	<input type="checkbox"/> Erythromycin	_____
<input type="checkbox"/> Nitrous Oxide	<input type="checkbox"/> Valium	Are you taking any medications? What?
<input type="checkbox"/> Tetracycline	<input type="checkbox"/> Penicillin	_____
<input type="checkbox"/> Local Anesthetic	<input type="checkbox"/> Other	Family Physician _____ Phone Number _____

Patient Signature (Parent of Child)	Date			
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