PATIENT REGISTRATION

Today's Date _____

Patient's Name **Sex: M F** **Birthdate** **Age**

Home Address | City | State | Zip

Please Circle One: Single Married Separated Widow | Your Soc. Sec. #

Home Ph.# | Cell Ph. # | E-mail Address

Your Employer | Work Ph. # | How Long Employed

Are you a full time student? ☐ Yes ☐ No *If patient is minor we need:* | *Mother's DOB* | *Father's DOB*

Person responsible for account | Driver's License # | Relationship

Name of spouse (parent if minor) | Spouse's (parents) Soc. Sec. #

Spouse's (parent's) Employer | Work Ph. # | Cell Ph. #

EMERGENCY INFORMATION
Name, address, & telephone of a relative not living with you

Reason for this visit

How did you hear about our office?

FAMILY PHYSICIAN _____ **PHONE NO.** _____

DENTAL INSURANCE INFORMATION (Primary Carrier)	**If you have double digit insurance coverage, complete this for the 2nd coverage**
Insured's name	Insured's name
Insured's employer	Insured's employer
Insurance Co	Insurance Co
Insurance Co Address	Insurance Co Address
Phone # DOB	Phone # DOB
SS#	SS#
Group # Local #	Group # Local #

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 that you read, agree to, and sign prior to any treatment. Please note 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 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 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 will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

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.

Consent:

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. 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 have been made. I further understand that a finance, rebilling, collection charge and/or attorney fee will be added to any overdue balance.

By signing below, you are authorizing us to call you at any number you provide including calls to mobile/cellular or similar devices for any lawful purpose. You agree to any fees or charges that you may incur for an incoming call from us, and/or outgoing calls to us, to or from any such number, without reimbursement from us.

_____ _____

Patient Signature (Parent if child) **Date**

MEDICAL HISTORY

	YES	NO	If yes, explain:
Do you have any CURRENT HEALTH PROBLEMS?	☐	☐	
Are you under a PHYSICIAN'S CARE now?	☐	☐	
Are you currently taking any medication?	☐	☐	**If Yes, Please List**

Pharmacy Used: _____

Do you take a blood thinner? Yes ☐ No ☐, if so What? _____ Why? _____

Is there any other Medical or Dental information that you feel we should know about? _____

Please check yes or no to the following problems/conditions:

	YES	NO		YES	NO		YES	NO		YES	NO
AIDS	☐	☐	COPD	☐	☐	Hepatitis B	☐	☐	Respiratory Problems	☐	☐
Allergies (Seasonal)	☐	☐	Cortisone Medication	☐	☐	Hepatitis C	☐	☐	Rheumatic Fever	☐	☐
Anemia	☐	☐	Diabetes	☐	☐	High Blood Pressure	☐	☐	Rheumatism	☐	☐
Angina (Chest Pain)	☐	☐	Dizziness	☐	☐	HIV Positive	☐	☐	Scarlet Fever	☐	☐
Arthritis	☐	☐	Drug Addiction	☐	☐	HPV	☐	☐	Seizures	☐	☐
Artificial Heart Valve	☐	☐	Emphysema	☐	☐	Jaundice	☐	☐	Sinus Problems	☐	☐
(pre-medication)	☐	☐	Epilepsy	☐	☐	Jaw Joint Pain	☐	☐	Sleep Apnea	☐	☐
Artificial Joints	☐	☐	Excessive Bleeding	☐	☐	Kidney Disease	☐	☐	Stomach Problems	☐	☐
(pre-medication)	☐	☐	Fainting	☐	☐	Liver Disease	☐	☐	Stroke	☐	☐
Asthma	☐	☐	Glaucoma	☐	☐	Low Blood Pressure	☐	☐	Thyroid Disease	☐	☐
Blood Disease	☐	☐	Heart Conditions	☐	☐	Mitral Valve Prolapse	☐	☐	Tuberculosis	☐	☐
Bruise Easily	☐	☐	Heart Lesions	☐	☐	Nervousness/	☐	☐	Ulcers	☐	☐
Cancer	☐	☐	(Congenital)			Depression			Venereal Diseases	☐	☐
CBD Oil	☐	☐	Heart Murmur	☐	☐	Pacemaker	☐	☐	Other _____		
Cervical Cancer	☐	☐	Heart Surgery	☐	☐	Pregnant Currently	☐	☐	_____		
Chemotherapy	☐	☐	Hepatitis A	☐	☐	Radiation (head/neck)	☐	☐	_____		

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

	YES	NO		YES	NO		YES	NO
Aspirin	☐	☐	Erythromycin	☐	☐	Soy	☐	☐
Augmentin	☐	☐	Latex	☐	☐	Sulfa	☐	☐
Clindamycin	☐	☐	Local Anesthetic	☐	☐	Sulfites	☐	☐
Codeine	☐	☐	Nitrous Oxide	☐	☐	Valium	☐	☐
Eggs	☐	☐	Penicillin	☐	☐			

Other _____

_____

_____

_____

Have you ever taken any of the following medications for Osteoporosis or Cancer tx?

	YES	NO		YES	NO		YES	NO		YES	NO
Actonel	☐	☐	Fosamax	☐	☐	Xgeva	☐	☐	Herbal Supplements	☐	☐
Aredia	☐	☐	Prolia	☐	☐	Zometa	☐	☐			
Boniva	☐	☐	Reclast	☐	☐						

Do you smoke, vape or use chewing tobacco? YES ☐ NO ☐
How Much? _____
For How Long? _____

Do you drink Alcohol? YES ☐ NO ☐
How Much/How Often? _____
For How Long? _____

Do you use Marijuana? YES ☐ NO ☐
How Often? _____
For How Long? _____

CONSENT:
The undersigned herby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read, understand and agree to the above terms and conditions.

_____ _____ _____

Patient Signature (Parent if child) **Date** **Doctor Signature**