Patient Registration

Patient Name				
Patient Number ABC	Sex: ❑ M ❑ F	Birthdate	Age	Today's Date
Home Address		City	State	Zip
Please Check One: ❑ Single ❑ Married ❑ Separated ❑ Widow	Occupation			
Email Address	Cell Phone Number			Home Phone Number
Your Employer	How Long Employed	Your Soc Sec. #		Work Phone
Are you a full time student? ❑Yes ❑ No	*If patient is minor we need Mother's Birth Date and Father's Birth Date:*			
Person responsible for account		Driver's license number		
Name of spouse (Parent if minor)		E-mail address		Cell Phone
Spouse's (parent's) employer	Spouse's Soc. Sec. #			Work phone
How did you hear about our office?		**EMERGENCY INFORMATION** Name, Address, & telephone of a relative **not** living with you.		
Reason for this visit				

Dental Insurance Information

DENTAL INSURANCE INFORMATION (Primary Carrier)		
Insured's name	DOB	SS#
Insured's employer		
Insurance Co		
Insurance Co Address		
Phone #		
Group #		Local #

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, 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.

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.

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.

Signature _____ Date _____

(Patient or Guardian)

Dental History

Please check any of the following problems that apply to you.

- ❑ Sensitivity (hot, cold, sweet)
  Where? UR LR UL LL
- ❑ Headaches, earaches, neck pain
- ❑ Jaw joint pain
- ❑ Teeth or fillings breaking
- ❑ Grinding or clenching teeth
- ❑ Bleeding, swollen or irritated gums
- ❑ Loose, tipped or shifting teeth
- ❑ Bad breath

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

- ❑ Dentures
- ❑ Partial dentures
- ❑ Braces
- ❑ Periodontal (gum) treatments

Please share the following dates:

Your last cleaning ___ / ___
Your last oral cancer screening ___ / ___
Your last complete X-Rays ___ / ___

Name of Previous Dentist _____

City State

Phone Number

What is the most important thing to you about your future smile and dental health?

If you could whiten your teeth for a cost anyone could afford, would you do it? ❑ Yes ❑ No

Do you smoke or use chewing tobacco?
How much? For how long?

If I could change my smile, I would:

- ❑ Make them whiter
- ❑ Make them straighter
- ❑ Close spaces
- ❑ Replace black metal fillings with tooth colored restorations
- ❑ Repair chipped teeth
- ❑ Replace missing teeth
- ❑ Replace old crowns that don't match
- ❑ Have a smile makeover

On a scale of 1 –10, with 10 being the highest rating:

How important is your dental health to you?
1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10

Where do you want your dental health to be?
1 2 3 4 5 6 7 8 9 10

Why did you leave your previous dentist?

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:

- ❑ AIDS
- ❑ Allergies (Seasonal)
- ❑ Anemia
- ❑ Arthritis
- ❑ Artificial Heart Valve
- ❑ Artificial Joints
- ❑ Asthma
- ❑ Blood Disease
- ❑ Bruise Easily
- ❑ Cancer
- ❑ Chemotherapy
- ❑ Diabetes
- ❑ Dizziness
- ❑ Drug Addiction
- ❑ Emphysema
- ❑ Excessive Bleeding
- ❑ Fainting
- ❑ Glaucoma
- ❑ Heart Conditions
- ❑ Heart Lesions (Congenital)
- ❑ Heart Murmur
- ❑ Heart Surgery
- ❑ Hepatitis A
- ❑ Hepatitis B
- ❑ Hepatitis C
- ❑ High Blood Pressure
- ❑ HIV Positive
- ❑ Jaundice
- ❑ Jaw Joint Pain
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Low Blood Pressure
- ❑ Mitral Valve Prolapse
- ❑ Nervousness/Depression
- ❑ Pacemaker
- ❑ Periodontal Disease
- ❑ Phen Fen (1 month +)
- ❑ Pregnant Currently
- ❑ Radiation (head/neck)
- ❑ Respiratory Problems
- ❑ Rheumatic Fever
- ❑ Rheumatism
- ❑ Scarlet Fever
- ❑ Seizures
- ❑ Stomach Problems
- ❑ Stroke
- ❑ Thyroid Disease
- ❑ Tuberculosis
- ❑ Ulcers
- ❑ Venereal Diseases
- ❑ Other

Do you have any of the following drug allergies?

- ❑ Aspirin
- ❑ Percodan
- ❑ Local Anesthetic
- ❑ Codeine
- ❑ Darvon
- ❑ Erythromycin
- ❑ Nitrous Oxide
- ❑ Penicillin
- ❑ Sulfa
- ❑ Valium
- ❑ Other

Are you under a physician's care? What for?

Are you taking any medications? What?

Family Physician **Phone Number**

Print Name: _____ Is there any other medical or dental information we should know about? _____

Signature (Patient or Guardian)_____ Date _____ Dentist Signature_____