

Patient Registration Form

Email: _____				Today's Date: _____	
Preferred Name: <input type="checkbox"/> Miss <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Dr.			Referred by: _____		
Name: _____		Home Phone: <i>include area code</i> () ()		Cell Phone: <i>include area code</i> () ()	
Last		First		Middle	
Address: _____ <small>Mailing address</small>			City: _____		State: _____ Zip: _____
SS#: _____		Date of Birth: _____		Sex: M F	
Employer: _____			Business Phone: <i>include area code</i> () ()		
Emergency Contact: _____		Relationship: _____		Home Phone: <i>include area code</i> () () Cell Phone: <i>include area code</i> () ()	
College Student Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time			Please provide school info: _____		School Name: _____
Employment Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired			Address: _____		
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed			Address 2: _____		
Pref. Pharmacy: _____		Phone: () ()		City, State, Zip: _____	

Dental Insurance Information

Primary Insurance Information	
Name of Insured: _____	Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
Insured Soc. Sec.: _____	Insured Birth Date: _____
Employer: _____	Ins. Company: _____
Address: _____	Address: _____
Address 2: _____	Address 2: _____
City, State, Zip: _____	City, State, Zip: _____
ID#: _____ Gr#: _____	
Secondary Insurance Information	
Name of Insured: _____	Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
Insured Soc. Sec.: _____	Insured Birth Date: _____
Employer: _____	Ins. Company: _____
Address: _____	Address: _____
Address 2: _____	Address 2: _____
City, State, Zip: _____	City, State, Zip: _____
ID#: _____ Gr#: _____	

Dental Information

For the following questions, mark (X) your responses to the following questions.

	Yes	No	DK		Yes	No	DK
Do your gums bleed when you brush or floss?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have earaches or neck pains?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to cold, hot, sweets or pressure? .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any clicking, popping or discomfort in the jaw?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your mouth dry?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you brux or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any periodontal (gum) treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have sores or ulcers in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had orthodontic (braces) treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear dentures or partials?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any problems associated with previous dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you participate in active recreational activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your home water supply fluoridated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a serious injury to your head or mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink bottled or filtered water?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date of your last dental exam: _____			
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY				What was done at that time? _____			
Are you currently experiencing dental pain or discomfort? <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date of last dental x-rays: _____			
What is the reason for your dental visit today?							
How do you feel about your smile?							

Medical Information Please mark (X) your responses to indicate if you have or have not had any of the following diseases or problems.

(Check DK if you Don't Know the answer to the question) Yes No DK	Yes No DK
Are you now under the care of a physician? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Physician Name: _____ Phone: include area code (_____) _____ Address/City/State/Zip: _____	Have you had a serious illness, operation or been hospitalized in the past 5 years? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> If yes, what was the illness or problem? _____
Are you in good health? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Has there been any change in your general health within the past year? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> If yes, what condition was treated? _____	Are you taking or have you recently taken any prescription or over the counter medicine(s)? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements: _____ _____
Date of last physical exam: _____	Do you use controlled substances (drugs)? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Do you wear contact lenses? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you use tobacco (smoking, snuff, chew, bidis)? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> If so, how interested are you in stopping? Circle one: VERY / SOMEWHAT / NOT INTERESTED
Are you taking, or have you taken, any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine) or fen-phen (fenfluramine-phentermine combination)? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you drink alcoholic beverages? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> If yes, how much alcohol did you drink in the last 24 hours? _____ If yes, how much do you typically drink in a week? _____
Are you taking or scheduled to begin taking either of the medications alendronate (Fosamax®) or risendronate (Actonel®) for osteoporosis or Paget's disease? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	WOMEN ONLY Are you: Pregnant? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Number of weeks: _____ Taking birth control pills or hormone replacement? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nursing? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Date Treatment Began: _____	

Joint Replacement. Have you had an orthopedic total joint replacement (hip, knee, elbow, finger)?
Date: _____ If yes, have you had any complications? _____

Allergies - Are you allergic to, or have you had a reaction to: **Yes No DK**
To all **yes** responses, specify type of reaction.

Local anesthetics <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Metals <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Aspirin <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Latex (rubber) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Penicillin or other antibiotics <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Iodine <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Barbituates, sedatives, or sleeping pills <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Hay fever / seasonal <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Sulfa drugs <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Animals <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Codeine or other narcotics <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Food <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
	Other <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

Yes No DK	Yes No DK	Yes No DK	Yes No DK
Heart murmur <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Anemia <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Chest pain upon exertion <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Neurological disorders <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Mitral valve prolapse <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Blood transfusion <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Chronic pain <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	If yes, specify: _____
Artificial heart valves <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	If yes, date: _____	Diabetes Type I or II <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Sleep disorder <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Rheumatic fever <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Hemophilia <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Eating disorder <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Mental health disorders <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Cardiovascular disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	AIDS or HIV infection <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Malnutrition <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	If yes, specify: _____
Angina <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Arthritis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Gastrointestinal disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Recurrent infections <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Arteriosclerosis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Autoimmune disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	G.E. Reflux/Persistent heartburn <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Type of infection: _____
Congestive heart failure <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Rheumatoid arthritis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Ulcers <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Kidney problems <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Coronary artery disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Systemic lupus erythematosus <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Thyroid problems <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Night sweats <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Damaged heart valves <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Asthma <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Stroke <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Osteoporosis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Heart attack <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Bronchitis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Glaucoma <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Persistent swollen glands in neck <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Low blood pressure <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Emphysema <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Hepatitis, jaundice or liver disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Severe headaches/ Migraines <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
High blood pressure <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Sinus trouble <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Epilepsy <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Severe or rapid weight loss <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Congenital heart defects <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Tuberculosis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Fainting spells or seizures <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Sexually transmitted disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Pacemaker <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Cancer/Chemotherapy/ Radiation treatment <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		Excessive urination <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Rheumatic heart disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
Abnormal bleeding <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?
Name of physician or dentist making recommendation: _____ Phone: (_____) _____
Do you have any disease, condition, or problem not listed above that you think I should know about?
Please explain: _____

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.
Signature of Patient/Legal Guardian: _____ Date: _____

Financial Policy

Thank you for choosing us as your dental health care provider. We believe that all patients deserve the very best dental care we can provide. We also believe that everyone benefits when specific financial arrangements are agreed upon. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require that you read and sign prior to any treatment. All patients must complete our information and insurance forms before seeing the doctor. FULL PAYMENT IS DUE AT TIME OF SERVICE. We accept cash, checks, debit cards, Visa, Mastercard, American Express and Discover credit cards.

1. INSURANCE

We request that any co-payments, deductibles, and any services not covered by your insurance plan be paid at the time the service is provided. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance unless you bring in all insurance information at your initial visit. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your account in full within 45 days, the balance will be automatically transferred to your account. Please be aware some and possibly all of the services provided may be non-covered services and not considered reasonable, usual, and customary under the terms of your dental and/or medical policy.

2. PAYMENT PLANS

We have partnered with Care Credit, a patient financing company, to offer our patients 0% interest financing for 3, 6, or 12 months with approval. No other payment plans are available.

3. APPOINTMENTS

Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit (\$50). Please understand that missed appointment times are valuable to those patients that may find it hard to come to the dentist at other times. Please help us serve you better by keeping your scheduled appointments. Excessive cancellations and no shows will result in termination of our treatment agreement and your records can be forwarded to another dental office. Please note that we do not accept cancellations via our website or email.

4. BILLING

All accounts which have not paid the estimated portion of their bill at the time of service will incur a \$3.00 billing charge each month until the balance is paid. Balances which are 60 days old or older will incur a monthly 1.5% finance charge with equals an 18% per annum rate. There is also a \$30 returned check fee.

5. REFUNDS

Refunds for overpayment will be sent after all treatment is completed and insurance has been collected.

6. COLLECTIONS

All accounts over 90 days will be notified in writing of the account being transferred to a collection agency. A finance charge is added to a patient's account each month that the bill is not paid. In the event of any costs incurred in the collection of fees (such as agency fees) due under this agreement, the additional cost will be added to the account. In the event your account becomes past due and is referred to an outside collection agency or attorney, you will be responsible for the collection costs (up to 33% of the balance due), along with reasonable attorney fees and court costs incurred.

I have thoroughly read the Financial Policy. I understand and agree to this Financial Policy.

PRINT NAME: _____

SIGNATURE: _____

DATE: _____

Informed Dental Treatment Consent

1. DIAGNOSTIC AND PREVENTIVE

I understand that radiographs are essential tools for assessment of my oral health as well as various oral diseases. I authorize the treating dentist to use professional judgment to provide the appropriate care. I also understand that I will have to sign a radiograph refusal form in the event I elect to not have radiographs recommended to me. (Initials _____)

2. DRUGS, MEDICATIONS AND LOCAL ANESTHETICS

I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). I also understand there are risks of local anesthesia that may affect my body such as dizziness, nausea, vomiting, accelerated/slow heart rate, or various types of allergic reactions. It may also cause injury to nerves that can result in pain, tingling, or numbness that may persist for several weeks, months, or rarely, be permanent. I understand the importance of informing the dental staff of my complete medical history, including any recent surgeries, changes in my medical history, all medications and any known allergies. (Initials _____)

3. CHANGES IN TREATMENT PLANS

I understand that during treatment it may be necessary to change and/or add procedures because of conditions found while working on the teeth that were not discovered during examination. Upon my consent, I give my permission to the Dentist to make any/all changes and additions as necessary. (Initials _____)

4. REMOVAL OF TEETH

Alternatives to removal will be explained to me (root canal therapy, crowns, and periodontal surgery, etc.), should extractions be necessary. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (Paresthesia) that can last for an indefinite period of time (days or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility. (Initials _____)

5. CROWNS AND BRIDGES

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size and color) will be before cementation. Once cemented, I understand that any changes in shape, fit, size, or color will incur an additional charge. (Initials _____)

6. DENTURES (COMPLETE OR PARTIAL)

I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing these appliances will be explained to me, including looseness, soreness, and possible breakage. I realize the final opportunity to make changes, including shape, fit, size, placement, and color, must be discussed at the "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee. I also understand that wearing dentures may be difficult and/or painful. Dentures usually require several follow-up visits. I understand that failure to keep my appointments may result in ill-fitting dentures. If a remake is required due to my delays of more than 30 days, there will be additional charges. (Initials _____)

7. ENDODONTIC TREATMENT (ROOT CANALS)

I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment. I understand that root canals can fail and may require additional treatment, or I may end up having the tooth extracted. I also understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy). (Initials _____)

8. PERIODONTAL TREATMENT (TISSUE & BONE)

I understand that I have a serious condition, causing gum and bone infection that can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition. (Initials _____)

9. FILLINGS

I understand that I may experience hot and cold sensitivity, pain or discomfort following routine restorative procedures and that this is usually temporary and should settle without further treatment. If in the event that my condition does not get any better, I understand that I may need further dental treatment, the most common being root canal therapy, resulting in additional costs. (Initials _____)

PRINT NAME: _____

SIGNATURE: _____

DATE: _____

HIPAA AUTHORIZATION

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- Day-to-day operations of the practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that Cities Dental Studio is not required to agree to these requested restrictions. However, if Cities Dental Studio agrees, Cities Dental Studio is then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

I authorize the following person/people to receive and/or discuss my dental treatment, finances, appointments or current health status:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Date: _____

Name: _____

Signature: _____