Patient Registration

Patients Name _____ **Sex: M F Birthdate** _____ **Age** _____

Home Address _____ City _____ State _____ Zip _____

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

Home Ph. # _____ Cell Ph. # _____ E-mail _____

Your Employer _____ Work Ph. # _____ Years Employed _____

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

Person responsible for account _____ Driver License # _____ Relationship _____

Name of Spouse (Parent if minor) _____ Spouses (Parent's) Soc. Sec. # _____

Spouse's (parent's) Employer _____ Work # _____ Cell # _____

Reason for visit _____

Referring Dentist _____

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's name _____

Insured's employer _____

Insurance Co _____

Ins. Ph. # _____

Subscriber SS# _____ DOB _____

Group # _____ Local # _____

If you have dual insurance coverage, complete this for the 2nd coverage

Insured's name _____

Insured's employer _____

Insurance Co _____

Ins. Ph. # _____

Subscriber SS# _____ DOB _____

Group # _____ Local # _____

Financial Policy

Thank you for choosing our office as your periodontal healthcare provider. We are committed to providing you with the highest quality care, s 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 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.

* **This office is not "in network" with any insurance plan other than Delta Premier and the Boeing Company Delta Dental Plan**

* **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 periodontal healthcare 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 call to us, to or from any such number, without reimbursement from us.

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

Medical History

Physician's Name_____ Ph. #_____ Date of last exam_____

Are you currently being treated by a physician?_____ If yes, for what_____

List medications you are currently taking_____

_____

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

Aspirin	Y	N	Percodan	Y	N	Tetracycline	Y	N	Valium	Y	N
Darvon	Y	N	Latex	Y	N	Codeine	Y	N	Penicillin	Y	N
Nitrous	Y	N	Anesthetic	Y	N	Erythromycin	Y	N	Sulfa	Y	N

Other_____

_____

_____

Have you ever taken any of the following medications?

Do you pre-medicate prior to dental procedures? _____

Actonel	Y	N	Aredia	Y	N	Fosamax	Y	N	Bisphosphonates	Y	N
Boniva	Y	N	Reclast	Y	N	Herbal Supplements	Y	N			

If yes, state reason_____

Do you take Aspirin daily?_____ How much_____mg_

Have you ever smoked/Vapor?_____ How Much?_____ For how long?_____ When did you quit?_____

Women: Are you pregnant?_____ Due date_____ Are you taking birth control?_____

Are you on Hormone Replacement Therapy?_____ If so, what type_____

Please check any of the following problems/conditions that apply to you:

_____Alcoholism	_____Depression	_____HIV/AIDS	_____Pacemaker
_____Allergies(Seasonal)	_____Epilepsy/Seizures	_____Kidney Disease	_____Radiation/Chemo
_____Anemia	_____Excessive bleeding	_____Liver Disease	_____Respiratory Problems
_____Anxiety	_____Fainting/Dizziness	_____Low Blood Pressure	_____Rheumatic Fever
_____Arthritis	_____Gall Bladder Disease	_____Mental Disorders	_____Scarlet Fever
_____Artificial Joints	_____Glaucoma/Cataracts	_____Migraines	_____Sinus Problems
_____Aspirin Therapy	_____Hay Fever	_____Mitral Valve	_____Sleep Apnea
_____Asthma	_____Heart Disease	_____MVP w/ Regurgitation	_____Stomach Problems
_____Cancer/Tumor	_____Heart Murmur	_____Nervous Disorders	_____Stroke
_____Cholesterol	_____Hepatitis	_____Osteopenia	_____Thyroid Disease
_____Diabetes (Sugar)	_____High Blood Pressure	_____Osteoporosis	_____Tuberculosis
			_____Ulcers
			_____Venereal Disease

Do you have any disease, condition or problem not listed above?_____

_____

Check all that apply to you:

Do you have pain in the chest upon exertion?_____

Do you have shortness of breath after mild exercise?_____

Are you constantly thirsty?_____

Do you have difficulty swallowing?_____

Does your mouth become dry often?_____

Do you have to urinate more than 6 times a day?_____

Do your ankles swell?_____

Do you bruise easily?_____

DENTAL HISTORY

List any problems associated with prior dental treatment:_____

What is your chief complaint concerning your mouth or teeth?_____

Briefly state your feelings toward dentures:_____

***Yes *No** Do you bleed excessively after tooth extraction?

***Yes *No** Do you clench or grind your teeth?

***Yes *No** Have you had excessive swelling or pain after oral surgery?

***Yes *No** Do you have a bad taste in your mouth?

***Yes *No** Does your jaw click or pop when you chew?

***Yes *No** Have you had any adverse reactions to local or general anesthetics?

***Yes *No** Are any of your teeth sensitive to cold or sweets?

***Yes *No** Do you have bleeding gums?

***Yes *No** Does food pack between your teeth?

***Yes *No** Has a dentist ever ground your teeth to correct your bite?

***Yes *No** Have you been treated for Periodontal Disease in the past?

***Yes *No** If diagnosed, are you willing to become actively involved in the treatment of periodontal disease?

_____

Consent:

The undersigned herby authorizes Periodontics of O'Fallon to perform any and all forms of treatment, medication and therapy that may be indicated. I authorize the release of any information relating to dental treatments to third party payers and/or other health practitioners for myself or dependents by this office. I understand I am responsible to pay my co-payment at the time of service and that Periodontics of O'Fallon will submit claims to my insurance company as a courtesy. I understand that this office is not "in network" with any insurance plan other than Delta Premier and the Boeing company, and that I am responsible to know my insurance benefits. I have read the above conditions of treatment and agree to their content.

Patient/Guardian_____ Date_____ Doctor Signature_____