Candace L. Peterson, DMD

PATIENT REGISTRATION

Date _____

A. Responsible Party _____SS #_____-_____-_____
Last First Middle

Home Address _____ Birthdate _____

_____ _____ _____
City State Zip Code

Home Phone (_____) _____-_____ Cell Phone (____) _____-_____ Work Phone (____) _____-_____

Employer _____ Occupation _____

Spouse _____ Birthdate _____ SS#_____-____-_____
Last First Middle

Spouse Employer _____Work Phone (____)____-_____ Cell (____)____-_____

Marital Status (check one): Single_____ Married _____ Divorced _____ Separated _____ Widowed_____

B. Child Information:

1. _____ Birthdate: _____ Ins coverage: YES/NO
2. _____ Birthdate: _____ Ins coverage: YES/NO
3. _____ Birthdate: _____ Ins coverage: YES/NO
4. _____ Birthdate: _____ Ins coverage: YES/NO

C. Payment is due at time of service. What method of payment will you use?

Cash _____ Check _____ Credit Card _____

Insurance Co. _____ Subscriber's Name _____

Insurance Address _____ _____ _____ _____
Street City State Zip

Phone (____) _____-_____ Group # _____ Subscriber ID #_____

Subscriber Date of Birth _____

Insurance Co. _____ Subscriber's Name _____

Insurance Address _____ _____ _____ _____
Street City State Zip

Phone (____) _____-_____ Group # _____ Subscriber ID # _____

Subscriber Date of Birth _____

D. In case of EMERGENCY:

Relative to contact (other than spouse) _____ Phone (____) _____-_____

E. Whom may we thank for referring you to our office?

_____

HEALTH HISTORY

Although dentists primarily treat the area in and around your mouth, it is important for us to know all facts relative to your present and past health. Certain medications and health conditions could have an important interrelationship with the treatment that you will be receiving. The following information is strictly confidential.

Patient's Name: _____ Date of Birth: _____

Name you prefer to be called: _____ Sex: M F

Date of last Physical Examination: _____ Physician's Name: _____

General Health (please check) ___ Excellent ___Good ___Fair ___ Poor

Have you been hospitalized during the past two years? _____ For _____

Have you been under the care of a physician in the past two years? _____ For_ _____

Have you ever had major surgery? _____

WOMEN: Are you pregnant or nursing? _____ Taking Birth Control or hormones? _____

MEN: Are you taking Viagra? _____

Are you allergic to: (*Circle Please*) Penicillin Other antibiotics Aspirin Codeine Local anesthetics Any Metals

Latex Rubber Other (please list) _____

Do you smoke? _____ Do you consume alcoholic beverages? _____

Please ***circle*** any of the following that you have had or have at present: None apply: _____

AIDS
Allergies
Abnormal blood pressure
Anemia
Angina
Arthritis
Artificial Heart Valve – when ____
Artificial Joints – when _____
Asthma
Blood Disorders
Cancer – currently Y N
Canker Sores/Cold Sores
Cardiac Pacemaker – when ____
Chemotherapy
Congenital Heart Lesions
Diabetes
Drug /Alcohol Dep. treatment
Eating Disorder
Emphysema
Epilepsy
Fainting
Glaucoma
Heart Attack – when_____
Heart Disease
Heart Murmur
Hepatitis – type _____
Herpes
HIV positive
Jaundice
Kidney Disease
Liver Disease
Lung Disease
Mitral Valve Prolapse
Organ Transplant - when_____
Polio
Prolonged cough
Psychiatric treatment
Radiation therapy
Respiratory problems
Rheumatic Fever
Stroke – when _____
Swollen ankles
Thyroid disease
Tuberculosis
Ulcers/Gastric reflux
Venereal disease
Other _____

Please list all medications you are currently taking:

Condition	Medication	Dosage

How would you rate your dental health? ____ Good ____ Fair ____ Poor

Name of previous dentist _____ Date of last visit _____

Are you having any dental problems that require immediate attention?_____

Do any of the following cause tooth discomfort? Hot ☐ Cold ☐ Sweets ☐ Chewing ☐

Have you ever had an unpleasant dental experience? _____

How often do you brush? _____ Floss? _____ Other? _____

Do your gums bleed or hurt while brushing or flossing? _____

Have you had treatment for gum disease? Yes ☐ No ☐ When? _____

Do you clench or grind your teeth? Yes ☐ No ☐ When? _____

Do your jaws ever feel tired or ache? Yes ☐ No ☐ Click or pop? Yes ☐ No ☐

Can you chew on both sides of your mouth? Yes ☐ No ☐ Comfortably? Yes☐ No ☐

Do you have frequent headaches? Yes ☐ No ☐ Earaches? Yes ☐ No ☐

Are you currently taking fluorides? Yes ☐ No ☐ Do you object to fluoride if recommended? Yes ☐ No ☐

Have you had difficulty healing following an extraction or other dental treatment? _____

Is there anything about your mouth, teeth or smile that you do not like (function, appearance or color)?

_____

Have you had instruction in preventative dentistry? Yes ☐ No ☐

Have you ever had your teeth whitened? _____ Are you interested in whitening your teeth? _____

To the best of my knowledge, all of the information on this form is true and correct. If there is any change in my health, or my medications, I will inform the doctor prior to any treatment.

Signature: _____ Date: _____

NOTES:_____

_____

_____

_____

CONSENT FOR TREATMENT: I hereby authorize Dr. Candace Peterson to administer anesthetics and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures and anesthetics.

Signature: _____ Date: _____

For our patient's benefit, we ask that payment be made at the time of service. This keeps administrative costs down so we can keep our fees as reasonable as possible. If you have insurance, as a courtesy we will call for a breakdown of your benefits and then bill them directly following services. **We do ask, however, that any portion *estimated* not to be covered by insurance be paid at the time of service**. We can only estimate what your insurance will pay. In the event a balance remains on your account, please be aware that a billing charge of 1.5% per month (18% annually) will be assessed on all balance over 60 days, with a $5.00 monthly minimum. If you overpay, a refund will promptly be sent. We offer several options for payment, including cash, check, VISA, MasterCard, Discover and interest free financing through Care Credit. A $25 charge will be assessed for returned checks.

This signature on file is my authorization for the release of information necessary to process my claim. I authorize my insurance company to send payment directly to Candace Peterson, DMD.

Signature: _____ Date:_____

We value your time and ask that you value ours as well. In order to provide the best service possible, patients are seen by appointment only. *Each appointment you are given is reserved exclusively for you.* If you need to reschedule an appointment, we ask that you give us 2 business days notice so that we can utilize that time for another patient requiring attention. We understand that your time is very important and we work very hard to stay on time. We ask that you arrive on time as well. If you are late for an appointment, we will not be able to complete your treatment and see the following patient on time. If you arrive late or cancel without adequate notice (2 business days) you will be charged a minimum fee of $55 per hour of scheduled time. This fee must be paid before a new appointment will be scheduled.

If it becomes necessary to reschedule due to an emergency, we ask that you notify our office as quickly as possible so that we may use that time for another patient.

I acknowledge that I am financially responsible for all charges whether or not paid by insurance. After 90 days, delinquent accounts may be assigned to a credit reporting collection agency and a fee of $75 will be added to your account. The undersigned agrees to pay for all collection costs and expenses, including reasonable attorney fees and court costs. I hereby authorize the doctor to release information necessary to secure the payment.

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me.

Signature: _____ Date: _____

You have my permission to contact me about appointments and treatment needs at the following phone numbers and e-mail address:

Home _____
Work _____
Cell _____ Text ok? Yes ☐ No ☐
E-mail _____

By signing below, I am indicating that I have read and understand the above statements.

_____
Print Name

_____ _____
Signature Date

We appreciate your business and look forward to serving you.