



Alvin C. Matthews, DDS, PC
FAMILY & COSMETIC DENTISTRY

7777 N. 43rd Avenue, Phoenix, AZ 85051

623-937-0267, FAX 623-847-3737

www.smilesbydrmatthews.com

PATIENT REGISTRATION

YOU

LAST NAME	FIRST	M.I.	NICKNAME
ADDRESS		CITY, STATE	ZIP
HOME PHONE	CELL	*EMAIL	
BIRTHDATE	AGE	SOC. SEC. # *IF NONE, CASH OR CC ONLY*	
DRIVER'S LICENSE #	STATE	*PLEASE PRESENT YOUR DRIVER'S LIC. FOR VERIFICATION	
OCCUPATION	EMPLOYER'S NAME		
EMP. ADDRESS	EMP. PHONE	FAX #	

CHILD

LAST NAME	FIRST	M.I.	NICKNAME
ADDRESS		CITY, STATE	ZIP
HOME PHONE	DATE OF BIRTH	SOCIAL SECURITY NUMBER	
SCHOOL	GRADE		

INSURANCE

INSURANCE COMPANY	GROUP NUMBER	EMPLOYER NAME
INSURED'S NAME	DATE OF BIRTH	RELATIONSHIP TO PATIENT
INSURED'S ID #	INSURED'S SOCIAL SECURITY #	***MUST HAVE THIS
SECONDARY INSURANCE COMPANY	GROUP NUMBER	EMPLOYER NAME
INSURED'S NAME	DATE OF BIRTH	RELATIONSHIP TO PATIENT
INSURED'S ID #	INSURED'S SOCIAL SECURITY #	

EMERGENCY CONTACT

NAME	RELATIONSHIP
ADDRESS	PHONE #

PERSON FINANCIALLY RESPONSIBLE FOR YOUR ACCOUNT

*YOU _____ YOUR SPOUSE _____ OTHER _____

NAME	ADDRESS	PHONE
RELATIONSHIP TO PATIENT	SOCIAL SECURITY #	DRIVER'S LICENSE #
OCCUPATION	EMPLOYER'S NAME	
EMP. ADDRESS	EMP. PHONE	FAX #

HOW DID YOU HEAR OF US?

FRIEND OR FAMILY _____

VALPAK COUPON ___ POSTCARD ___ YELLOW PGS ___ INTERNET ___ SIGN ___ OTHER _____

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now? Yes No If yes, please explain: _____
- Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____
- Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____
- Are you taking any medications, pills, or drugs? Yes No If yes, please explain: _____
- Do you take, or have you taken, Phen-Fen or Redux? Yes No _____
- Are you on a special diet? Yes No _____
- Do you use tobacco? Yes No _____
- Do you use controlled substances? Yes No _____

Women: Are you
 Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

- Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics
- Other If yes, please explain: _____

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

- | | | | |
|--|--|--|---|
| AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No | Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No | Hemophilia <input type="radio"/> Yes <input type="radio"/> No | Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No |
| Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No | Diabetes <input type="radio"/> Yes <input type="radio"/> No | Hepatitis A <input type="radio"/> Yes <input type="radio"/> No | Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No |
| Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No | Drug Addiction <input type="radio"/> Yes <input type="radio"/> No | Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No | Rheumatism <input type="radio"/> Yes <input type="radio"/> No |
| Anemia <input type="radio"/> Yes <input type="radio"/> No | Easily Winded <input type="radio"/> Yes <input type="radio"/> No | Herpes <input type="radio"/> Yes <input type="radio"/> No | Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No |
| Angina <input type="radio"/> Yes <input type="radio"/> No | Emphysema <input type="radio"/> Yes <input type="radio"/> No | High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No | Shingles <input type="radio"/> Yes <input type="radio"/> No |
| Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No | Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No | Hives or Rash <input type="radio"/> Yes <input type="radio"/> No | Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No | Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No | Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No | Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Joint <input type="radio"/> Yes <input type="radio"/> No | Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No | Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No | Spina Bifida <input type="radio"/> Yes <input type="radio"/> No |
| Asthma <input type="radio"/> Yes <input type="radio"/> No | Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No | Kidney Problems <input type="radio"/> Yes <input type="radio"/> No | Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No |
| Blood Disease <input type="radio"/> Yes <input type="radio"/> No | Frequent Cough <input type="radio"/> Yes <input type="radio"/> No | Leukemia <input type="radio"/> Yes <input type="radio"/> No | Stroke <input type="radio"/> Yes <input type="radio"/> No |
| Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No | Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No | Liver Disease <input type="radio"/> Yes <input type="radio"/> No | Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No |
| Breathing Problem <input type="radio"/> Yes <input type="radio"/> No | Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No | Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No | Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No |
| Bruise Easily <input type="radio"/> Yes <input type="radio"/> No | Genital Herpes <input type="radio"/> Yes <input type="radio"/> No | Lung Disease <input type="radio"/> Yes <input type="radio"/> No | Tonsillitis <input type="radio"/> Yes <input type="radio"/> No |
| Cancer <input type="radio"/> Yes <input type="radio"/> No | Glaucoma <input type="radio"/> Yes <input type="radio"/> No | Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No | Tuberculosis <input type="radio"/> Yes <input type="radio"/> No |
| Chemotherapy <input type="radio"/> Yes <input type="radio"/> No | Hay Fever <input type="radio"/> Yes <input type="radio"/> No | Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No | Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No |
| Chest Pains <input type="radio"/> Yes <input type="radio"/> No | Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No | Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No | Ulcers <input type="radio"/> Yes <input type="radio"/> No |
| Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No | Heart Murmur <input type="radio"/> Yes <input type="radio"/> No | Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No | Venereal Disease <input type="radio"/> Yes <input type="radio"/> No |
| Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No | Heart Pace Maker <input type="radio"/> Yes <input type="radio"/> No | Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No | Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No |
| Convulsions <input type="radio"/> Yes <input type="radio"/> No | Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No | Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No | |

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____



INFORMED CONSENT and FINANCIAL POLICY

Please INITIAL each line:

____ I understand that the information I have given today is correct to the best of my knowledge. I also understand that it is my responsibility to inform this office of any changes in any medical status. I authorize the dental staff to perform any necessary dental services, such as x-rays, study models, photographs or any other diagnostic aid deemed appropriate by the doctor to make a thorough diagnosis. I also authorize the doctor (and his employees for assistance when applicable) to perform any and all forms of treatment, medication and therapy with my informed consent in connection with my diagnosis and treatment plan.

____ **Payment is required on the day of your visit.** Any discounts or coupons are void unless payment is made on the day of service. We accept cash, personal check or major credit card (Visa, MasterCard, Am Ex, Discover). We also offer the option to arrange financing for services through outside companies.

____ We do our best to estimate the patient portion of your bill and that estimated amount is due at the time of your treatment. Any amount left owing after insurance has paid will be billed to you immediately and is due within 10 days of the statement. Balances left after 30 days will incur an 18% APR service charge. Breach of this responsibility carries the penalty of compensating the practice for any related attorney's and collections fees. If you have any questions about this policy, please ask one of our staff members before you receive treatment.

____ Regarding children of divorced parents – The parent that brings the child to our office treatment will be considered the financially responsible party for all charges on the child's account.

____ We also reserve the right to charge for appointments cancelled or broken without 48 hour notice at a rate of \$50 per appointment, or \$50 per hour which ever is greater. **Receiving payment at the time of service and keeping your appointment helps keep our costs and thus our fees down.*

Patient Name (Printed)

Patient/Parent or Guardian Signature

Date

IF YOU HAVE DENTAL INSURANCE: PATIENT AUTHORIZED SIGNATURE FORM

Please INITIAL each line:

____ The undersigned, hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my dentist to submit claims for benefits, for services rendered or for services to be rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

____ We do accept all Preferred Provider Organization (PPO) insurance plans, but are not IN-NETWORK with all of them. We are still very happy to file on your PPO as an OUT-OF-NETWORK provider, but the patient is responsible for any difference between our fee and the amount insurance pays. Many times, there is not much difference between IN-NETWORK and OUT-OF-NETWORK coverage. A large number of our patients who are OUT-OF-NETWORK realize that choosing the best dental treatment available for them is worth the occasional slightly higher co-pay.

____ I understand I am financially responsible to Alvin C. Matthews DDS, PC for charges not covered by this assignment. Breach of this responsibility carries the penalty of compensating the practice for any related attorney's and collections fees. Please remember that benefits coverage is a legal agreement between you and your insurance company. Our office is not involved in that agreement and your dental treatment is determined by your oral health, not your insurance company's reimbursement schedule. For the most accurate information regarding your benefits, please contact your insurance provider.

____ Your Social Security number is required for us to process your insurance benefits. If you do not wish to provide the Social Security number to us, we will require payment in full and will provide you with a form so you can submit the claim to the insurance company directly.

Authorized Signature of Covered Person/ Parent

Date

PRIVACY/ HIPPA NOTICE

Received

Declined

Initials _____

Date _____

LUMINEERS BY CERINATE SMILE EVALUATION

A Simple Quiz to Help You Obtain the Smile You've Always Wanted

NO PAIN—YOU DON'T EVEN NEED AN ASPIRIN.

THE MOST SIGNIFICANT COSMETIC ADVANCEMENT EVER!

Hold a mirror 12"–14" from your face. Smile to show your teeth. Take the time to observe your teeth carefully, then answer the following questions:

1 Do you like the appearance of your teeth and your smile? Yes No
If not, explain _____



STAINED AND CHIPPED

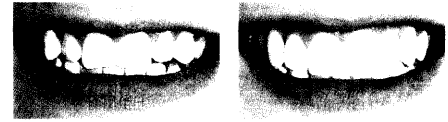
2 Are your teeth all in alignment (straight)? Yes No
If not, explain _____



SPACES

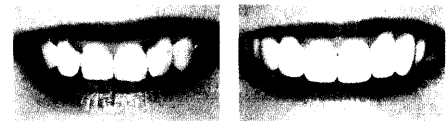
3 Do you have spaces that you don't like? Yes No
If yes, explain _____

4 Do you like the color of your teeth? Yes No
If not, explain _____



CALCIFICATION STAINS

5 Do you like the shape of your teeth? Yes No
If not, explain _____



FANGED TEETH

6 Are your teeth...
Chipped? Yes No Protruding Yes No Hidden Yes No
If yes, explain _____

7 Are your teeth wearing on the biting surfaces? Yes No
If yes, explain _____



STAINED AND CROOKED TEETH

8 Are there old fillings or dental work you don't like looking at? Yes No
If yes, explain _____

9 What would you like to change the most in the appearance of your teeth?



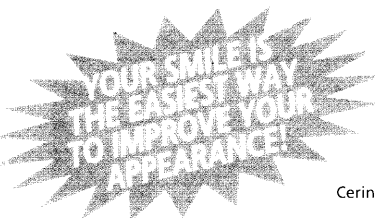
PORCELAIN CROWNS

10 How would you like your teeth to look?



BEAUTIFUL SMILE

If you are not happy with the appearance of your teeth, ask your dentist how LUMINEERS can improve your smile.



LUMINEERS
BY CERINATE
lumineers.com