CONFIDENTIAL

Patient Registration Information

Date_____

Name_____ Soc. Sec. #_____
First Mi Last

Email address _____ Cell Phone _____

Welcome to our practice!

Thank you for selecting our dental healthcare team. Please fill out this form completely in ink. If you have any questions or concerns, please do not hesitate to ask for assistance-we will be happy to help!

Home address_____ City_____ State_____ Zip_____

Birthdate_____Home Phone_____ Work Phone_____

Do you prefer to receive calls at: ☐ Work ☐ Home ☐ Either

Are you: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Your or your parent's employer_____ Occupation _____

Business address_____ City_____ State_____ Zip_____

Spouse or parent's name_____ Employer_____ Work phone _____

If you are a student, name of school/college_____ City_____ State ____

Whom may we thank for referring you? _____

Person to contact in case of an emergency_____ Phone _____

Responsible Party

Name of person responsible for this account_____ Relationship _____

Address_____ Home phone _____

City, State, Zip_____ Soc. Sec. # _____

Driver's license #_____ Birthdate_____ Financial institution_____

Employer_____ Work phone _____

Is this person currently a patient in our office? ☐ Yes ☐ No

Insurance Information

Name of insured _____

Relationship to patient _____

Birthdate_____Soc. Sec. #_____ Date employed_____

Employer_____ Work phone _____

Address of employer_____ City_____State_____Zip _____

Insurance company_____ Group #_____Employer/cert. #_____

Ins. co. address_____ City_____State_____Zip _____

How much is your deductible?_____How much have you used?_____Max. annual benefit? _____

Please Continue... ☞

Additional Insurance

Do you have any additional insurance? ☐ Yes ☐ No If yes, complete the following:

Name of insured _____

Relationship to patient _____

Birthdate _____ Soc. Sec. # _____ Date employed _____

Name of employer _____ Work phone _____

Address of employer _____ City _____ State _____ Zip _____

Insurance company _____ Group # _____ Employer/cert. # _____

Ins. co. address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit? _____

Please read the following carefully before signing:

Credit Authorization

I/we certify that the foregoing information has been supplied truthfully, accurately and voluntarily, and therefore authorize the named creditor to investigate my/our credit worthiness, credit history and financial responsibility through any credit bureau or by any other reasonable means, including direct contact with past and present creditors. I/we also authorize banks and other financial institutions to give information to the named creditor in connection with this transaction about my/our savings and checking accounts and loans. If credit is extended as a result of this application, I/we agree to make payment promptly in accordance with the creditor's usual terms.

_____
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We accept checks under these conditions

When you pay by check, you expressly authorize the merchant, if your check is dishonored or returned for any reason, to electronically debit your account for the amount of the check, plus a $25.00 processing fee. Your usage of a check for payment is your acceptance of this agreement and its terms

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Insurance

Please remember that insurance is a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage for the cost of those procedures. It is the responsibilty of the patient to pay any deductible, co-insurance, or any other balance not paid by the patient's insurance.

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Permission to Publicate

I am giving my permission for the doctor to use x-rays, pictures, and other diagnostic information in any articles he may submit for publication.

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Patient Medical History

PHYSICIAN _____ OFFICE PHONE _____ DATE OF LAST EXAM _____

PREVIOUS DENTIST _____ DATE OF LAST EXAM _____

	YES	NO
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness?	☐	☐
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐
If yes, what medication(s) are you taking? _____		
4. Do you use tobacco?	☐	☐
5. Do you use alcohol, cocaine or other drugs?	☐	☐
6. Are you wearing contact lenses?	☐	☐

7. Are you allergic to or have you had any reactions to the following?

YES	NO		YES	NO		YES	NO	
☐	☐	Local anesthetics (eg. novocaine)	☐	☐	Barbiturates	☐	☐	Aspirin
☐	☐	Penicillin or other antibiotics	☐	☐	Sedatives	☐	☐	Other _____
☐	☐	Sulfa Drugs	☐	☐	Iodine			_____

8. WOMEN ONLY:

	YES	NO
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking birth control pills?	☐	☐

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

YES	NO		YES	NO		YES	NO	
☐	☐	High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains
☐	☐	Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded
☐	☐	Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke
☐	☐	Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever / Allergies
☐	☐	Fainting / Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis
☐	☐	Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy
☐	☐	Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma
☐	☐	Epilepsy / Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss
☐	☐	Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease
☐	☐	Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble
☐	☐	Kidney Diseases	☐	☐	Hepatitis / Jaundice	☐	☐	Respiratory Problems
☐	☐	AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Lupus _____
☐	☐	Thyroid Problem	☐	☐	Stomach Troubles / Ulcers	☐	☐	Other _____

COMMENTS

Signature of Dentist Date

Patient Dental History

	YES	NO
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
a) Clicking?	☐	☐
b) Pain (joint, ear, side of face)?	☐	☐
c) Difficulty in opening or closing?	☐	☐
d) Difficulty in chewing?	☐	☐
8. Do you like your smile?	☐	☐
9. If I could change one thing about my smile it would be _____		

	YES	NO
10. Have you ever considered teeth whitening treatment?	☐	☐
11. Do you have frequent headaches?	☐	☐
12. Do you clench or grind your teeth?	☐	☐
13. Do you bite your lips or cheeks frequently?	☐	☐
14. Have you ever had any difficult extractions in the past?	☐	☐
15. Have you had any orthodontic work?	☐	☐
16. Have you ever had prolonged bleeding following extractions?	☐	☐
17. Have you ever had instruction on the correct method of brushing your teeth?	☐	☐
18. Have you ever had instructions on the care of your gums?	☐	☐
19. Have you ever been advised to premedicate prior to dental appointments?	☐	☐

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE X _____ _____

PATIENT, PARENT OR GUARDIAN DATE

Authorization, Release, and Agreement to Pay For Services Rendered

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such Dental care to third party payors and/or other health practitioners.

I authorize and hereby request my insurance company to pay directly to the dentist (or the dental group) insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

X _____ _____

Signature of patient or parent if minor — Date

Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option which you prefer. If you have any questions concerning financial arrangements or need special arrangements, please ask for assistance.

Payment in full at each appointment

_____Cash

_____Personal Check

_____Credit Card _____Visa _____MasterCard _____American Express _____Discover

Card #_____Expiration Date_____

Late Charges

If I do not pay the entire new balance within 60 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

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Thank you for filling out this form completely. The information you have provided will help us serve your dental healthcare needs more effectively and efficiently. If you have any questions at any time, please ask us. We are always happy to help.