REGISTRATION FORM

David L. Rens, DDS
Ann Marie Zimmerman, DDS

PATIENT INFORMATION

First Name: Middle Name: Last Name:

Address: City: San Diego State CA Zip Code:

Home Phone: Cell Phone: Office Phone:

I prefer to receive appointment reminders by: E-Mail Address

Date of Birth: Social Security Number: Marital Status

Relationship to Responsible Party: Referred by:

Emergency Contact (not living with you): Phone:

RESPONSIBLE PARTY

☐ Same as Above

First Name: Middle Name: Last Name:

Address: City: San Diego State CA Zip Code:

Home Phone: Cell Phone: Office Phone:

Date of Birth: Social Security Number: E-Mail Address

PATIENT'S DENTAL INSURANCE

Relationship to Insured Member: Insured's Name:

Insurance Company Group Number: Phone:

Address: City: State: Zip Code:

Employer: How many years?: Insurance ID:

SECONDARY DENTAL INSURANCE

Relationship to Insured Member: Insured's Name:

Insurance Company Group Number: Phone:

Address: City: State: Zip Code:

Employer: How many years?: Insurance ID:

Insured's Date of Birth: Insured's Social Security Number:

DENTAL HISTORY

Do you have any dental problems now?

Are your teeth sensitive to: ☐ Hot ☐ Cold ☐ Biting or Chewing ☐ Sweets

Have you noticed any mouth odors or bad tastes? ☐ Yes ☐ No

Do your gums bleed or hurt? ☐ Yes ☐ No

Have you noticed any loose teeth or change in you bite? ☐ Yes ☐ No

Are you aware of clenching or grinding your teeth while awake or asleep? ☐ Yes ☐ No

Have you ever smoked or chewed tobacco? ☐ Yes ☐ No

Do you have popping, clicking or pain from your TMJ joint? ☐ Yes ☐ No

From 1 to 10, how anxious are you about dental treatment?

Have you ever had:

- ☐ Orthodontic Treatment
- ☐ Oral Surgery
- ☐ TMJ Therapy
- ☐ Periodontal (Gum) Therapy
- ☐ Head or neck injury
- ☐ Bite Plane or Guard

How long ago was your last dental visit?

What was done at that time?

What would you like to change about your smile?

DENTAL AND FINANCIAL CONSENTS

Initials

☐ 1. I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. I acknowledge that upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required providing proper care. I agree to the use of anesthetic, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

☐ 2. I hereby give my consent for Drs. Rens and Zimmerman to take photographs, slides and/or videotape of face, jaw, and teeth. I understand that these images may be used to aid in the design and fabrication of crowns, veneers, bridges, or dentures and these images will become part of my dental record. The images may be shared with other health care practitioners or laboratories to facilitate my care. I also grant permission to reproduce, print and/or publish these images for use in articles, lectures, or promotional purposes. I may revoke this permission, in writing, at any time. I do not expect compensation, financial or otherwise, for the use of these images.

☐ 3. 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 understand that this information may be sent by mail or electronically on my behalf. I also acknowledge being informed of Doctors Rens and Zimmerman's Privacy Policy in accordance with the Department of Health and Human Services' Health Insurance Portability and Accountability Act.

☐ 4. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I agree that I shall be responsible for any and all expenses incurred at this office, and I understand that payment is due at the time of service unless other arrangements have been made, regardless if I have insurance. If I do not pay the entire new balance within 60 days of the monthly billing date, a late charge of 1.5% (18% Annual Percentage Rate) on the balance then unpaid and owed will be assessed each month. I authorize Drs. Rens and Zimmerman's office to contact me regarding financial issues on any phone number I provide to the office, including my cell phone. I realize that failure to keep this account current may result in this office not 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.

☐ 5. I consent to the dental practice using my cell phone number to call or text regarding appointments and to call regarding treatment, insurance, and my account. I understand that I can withdraw my consent at any time.

☐ 6. I authorize and hereby request my insurance company to pay directly to the dentist the insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services, and that I am responsible for payment of all services rendered on my behalf or on the behalf of my dependents. If I do not consent to this assignment of benefits, I understand that I will be expected to pay for services at the time they are rendered. The insurance company will then reimburse me directly.

Signature: _____ Relationship to Patient: Date:

Print Form