PATIENT REGISTRATION

Patient Information

Patient Name (First, Middle, Last)			Name You Prefer To Be Called
Home Address			Date of Birth
City	State	Zip	Soc. Sec. No.
Employed By	How Long	Present Position	Home Phone
Address of Employer			Business Phone
E-mail address		FAX	Cell Phone

Spouse Information Marital Status ☐ S ☐ M ☐ D ☐ W

Spouse Name (First, Middle, Last)			Date of Birth		Soc. Sec. No.
Address, If Different Than Patient					Home Phone
City	State		Zip		Business Phone
Employed By	How Long	Present Position			Emergency Phone
Address of Employer			City	State	Zip

Person Responsible for Account

Name (First, Middle, Last)		Relationship to Patient		Home Phone
Address, If Different Than Patient		City	State	Zip
Employer	Address			Business Phone

Emergency Contact

Closest relative not living with you	Relationship to Patient	Phone

Payment is due at time of service. If patient is covered by insurance, the insurance company will be billed. It is your responsibility to pay your portion at the time of service. Billing charges of 1.5% per month (minimum $5.00) will be assessed after 60 days . (See next page entitled Patient Registration Agreement for payment options). A $25.00 charge will be imposed for returned checks.

I acknowledge that I am financially responsible for *all charges whether or not paid by insurance.* If it becomes necessary to effect collections of amount due, the undersigned agrees to pay for all costs and expenses, including reasonable attorneys fees. I hereby authorize the doctor to release information necessary to secure the payment of benefits.

Signature_______________________________________ Date_____________________________

Who may we thank for referring you?______________________________ **Relationship**____________________

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 medical examination: __________ Physician's Name___________________ Phone #_______________

General Health (please check) Excellent ___ Good ___ Fair ___ Poor ___

Have you ever had a serious head or neck injury? ____

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

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

MEN: Are you taking medication for erectile dysfunction? ___________

Have you ever taken Fosamax, Boniva, Actonel or any other medication containing Bisphosphonates? ____________

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

Latex Rubber Acrylic Any Metals Other (please list) _____________________

Please *check yes or no* if you have had or have at present any of the following:

Abnormal blood pressure Yes □ No □
Allergies - seasonal Yes □ No □
Alzheimer's diagnosis Yes □ No □
Anaphylaxis Yes □ No □
Anemia Yes □ No □
Angina Yes □ No □
Arthritis Yes □ No □
Artificial Heart Valve Yes □ No □
When ________
Artificial Joints Yes □ No □
What/When_________________________
Asthma Yes □ No □
Autoimmune Disease Yes □ No □
Blood Disorders Yes □ No □
Cancer: (currently: Y N) Yes □ No □
Canker Sores/Cold Sores Yes □ No □
Cardiac Pacemaker Yes □ No □
Celiac Disease Yes □ No □
Chemotherapy Yes □ No □
Colitis Yes □ No □
Congenital Heart Lesions Yes □ No □
Depression/Anxiety Yes □ No □
Diabetes Yes □ No □
Drug /Alcohol Dep.Treatment Yes □ No □
Eating Disorder Yes □ No □
Emphysema Yes □ No □
Epilepsy Yes □ No □
Excessive Bleeding Yes □ No □

Fainting Yes □ No □
Glaucoma Yes □ No □
Heart Attack – when_______ Yes □ No □
Heart Disease Yes □ No □
Hepatitis – type ______ Yes □ No □
Herpes Yes □ No □
HIV positive/ AIDS Yes □ No □
Jaundice Yes □ No □
Kidney Disease Yes □ No □
Liver Disease Yes □ No □
Lung Disease Yes □ No □
Mental Disorders Yes □ No □
Organ Transplant: Yes □ No □
What/When_______________________
Osteoporosis Yes □ No □
Prolonged cough Yes □ No □
Radiation therapy Yes □ No □
Respiratory problems Yes □ No □
Rheumatic Fever Yes □ No □
Sinus Problems Yes □ No □
Stroke – when _______ Yes □ No □
Swollen ankles Yes □ No □
Thyroid disease Yes □ No □
Tuberculosis Yes □ No □
Ulcers/Gastric reflux Yes □ No □
Venereal disease Yes □ No □
Vertigo Yes □ No □
Other ______________________________

Do you smoke? _________________ Do you consume alcoholic beverages? __________

Please list all medications you are currently taking, including OTC and Naturopathic:

Condition	Medication	Dosage

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

Name of previous dentist ______________________ Phone # ______________ Date of last visit __________

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

Have you ever had an unpleasant dental experience? ____

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

How often do you brush? _______________ Floss? ________________ Other? _____________

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

Do your gums bleed or hurt while brushing or flossing? Yes ☐ No ☐

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 comfortably on both sides of your mouth? Yes ☐ No ☐

Do you have frequent headaches? Yes ☐ No ☐

Earaches? Yes ☐ No ☐

Do you currently have any dentures or partials? Yes ☐ No ☐

Are you currently taking fluorides? Yes ☐ No ☐

If you could change anything about your mouth, teeth, or smile, what would it be?_______________________

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Is there anything else you would like us to know?____

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Doctor Notes:____

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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.

Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, and other diagnostic aids deemed appropriate.

Signature: ____ Date: ________________
(Patient, parent or guardian)

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: ________________
(Patient, parent or guardian)

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. We do offer a 5% discount when you pay in full at the time of service using a check or cash. A $35 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) a fee will apply.** 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.

______________________________ Relationship to Patient: ____________________
Print Name

______________________________ ________________________
Signature Date

We appreciate your business and look forward to serving you.

Please respond to the following questions so we may serve you better:

Please rate your anxiety/fear of dental treatment:

Slight_____ Moderate_____ Extreme_____

Is there anything in particular that increases your anxiety? If yes, what?

Has anything in the past helped decrease your anxiety? If yes, what?

How much detail do you want us to share about a procedure?

None_____ General overview_____ Every detail_____

Would you like to see images of your teeth with our intraoral camera? Yes____ No____

Do you prefer a quiet atmosphere or conversation during treatment?

What did you like best about your last dental office?

Why did you leave your last dentist?

Is there anything else you would like us to know so we can best serve you?

Smile Assessment:

Are you comfortable showing your teeth when you smile?

Are you happy with the appearance of your teeth? If not, what would you change?

Shape____ Color____ Position____ Size____ Other________________________

Are you interested in improving the appearance of your teeth?

Is there anything holding you back from a perfect smile?

Lack of time____ Fear____ Cost____ Other________________________________