Patient Registration **Today's Date _____**

Last Name _____ First Name _____ MI____ Date of Birth_____ Age _____
Sex ☐ or ☐ Soc. Sec. # _____ Please Circle one: Single Married Separated Widow
Mailing Address _____ City _____ State _____ Zip Code _____
Home Phone (_____)_____ Cell Phone (_____)_____ Email _____
Occupation _____ Employer _____
Work Phone (_____)_____ Driver's License # _____
Are you a full time student? Yes or No **IF PATIENT IS A MINOR:** Mother's DOB _____ Father's DOB _____
Name of Parent _____ Parent Soc. Sec. # _____
Parent Employer _____ Parent Phone (_____)_____
Person Responsible for Account _____ Relationship _____
Emergency Contact _____ Relationship _____ Phone # (_____)_____
If you are filling this form out on behalf of another person, what is your relationship to that person?
Name _____ Relationship _____

Dental Insurance Carrier (Primary)_____	**Dental Insurance Carrier (Secondary)_____**
Insured's Name _____	Insured's Name _____
Insured's Employer _____	Insured's Employer _____
Insured's DOB _____	Insured's DOB _____
Insurance Co Address _____	Insurance Co Address _____
Insurance Phone # _____	Insurance Phone # _____
Group # _____ Local # _____	Group # _____ Local # _____

FINANCIAL POLICY

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment. Payment is due at the time service is provided. Our office accepts cash, personal checks, credit cards and outside patient financing.

Please check if you would like more information about financing options. ☐

Please Note: Returned checks will be subject to additional fees. If you have a balance on your account, we will send you a monthly statement. All accounts 60 days or more past due will be charged a 2% monthly interest fee in addition to a $5.00 late fee for every month your account is delinquent. It is the responsibility of the patient to clear their account within 120 days of when service was provided, unless prior financing arrangements have been made. Failure to pay for services within 120 days leaves us no choice but to proceed with a collection agency. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance you will be responsible for any collection and/or legal charges.

Your appointment time is reserved for you. If for any reason your appointment cannot be kept, notification should be made at least 24 hours in advance. A charge will be made for missed or same day cancellations at the office's discretion.

Do You Have Insurance?

- We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company.
- As a courtesy to you we will help you process your insurance claims. Should you require a pre-determination of benefits we are happy to provide one upon request, however, it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits will determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.
- We ask that you pay the deductible and co-payment, which is the estimated amount, not covered by your insurance company, by cash, check, credit card or Patient Financing at the time we provide the service to you.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

Consent: I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge and/or attorney fee will be added to any overdue balance. By signing below, you are authorizing us to call you at any number you provide including calls to mobile/cellular or similar devices for any lawful purpose. You agree to any fees or charges that you may incur for an incoming call from us, and/or outgoing calls to us, to or from any such number, without reimbursement from us.

_____ _____

Patient Signature (Parent or Guardian) **Date**

Dental History - Please mark (x) any of the following conditions that apply to you

Periodontal (Gum) Health
- ☐ Bleeding, Swollen, Irritated gums
- ☐ Bad breath
- ☐ Loose tipped, shifting teeth
- ☐ Previous perio/gum disease

Pain/Discomfort
- ☐ Sensitivity (hot, cold, sweet)
- ☐ Pressure
- ☐ Broken teeth/fillings
- ☐ Worn teeth
- ☐ Dry Mouth

Habits
- ☐ Thumb sucking
- ☐ Nail-biting
- ☐ Cheek/Lip biting
- ☐ Chewing on ice/foreign objects

Function
- ☐ Grinding/Clenching
- ☐ Headaches
- ☐ Jaw Joint (TMJ) pain
- ☐ Jaw Joint (TMJ) clicking/popping
- ☐ Bad Bite
- ☐ Speech Impediment
- ☐ Mouth Breathing
- ☐ Sore Muscles (neck, shoulders)
- ☐ Difficulty Opening or Closing
- ☐ Difficulty Chewing on either side

Comfort w/Dental Treatment
- ☐ Fear (dentists, needles, drill , etc)
- ☐ Anxiety
- ☐ Bad dental experiences
- ☐ Noises

Appearance
- ☐ Discolored teeth
- ☐ Worn teeth
- ☐ Misshaped teeth
- ☐ Crooked teeth
- ☐ Spaces
- ☐ Overbite
- ☐ Flatteeth

Sleep Pattern or Conditions
- ☐ Sleep Apnea
- ☐ Snoring
- ☐ Daytime Drowsiness
- ☐ Bed wetting (for children)

Social

Tobacco How much___ How long___
Alcohol Frequency_____
Drugs Frequency_____

Please list family history of any conditions marked above

_____
_____
_____

On a scale of 1-10, with 10 being highest rating, rate your smile __

Rate where you'd like it to be ___

What would you like to change about your smile?
- ☐ Color
- ☐ Chipped Teeth
- ☐ Crowding
- ☐ Missing Teeth
- ☐ Bite
- ☐ Spaces
- ☐ Smile Makeover
- ☐ Whiter Teeth

Please share the following dates:

Your last cleaning _____/
Your last oral cancer screening _____/_____
Your last complete X-rays

Name of your previous dentist _____
City _____ State _____
Phone _____
Why did you leave? _____

Medical History - Please mark (x) to your response to indicate if you have or have had any of the following

Cardiovascular
- ☐ Angina (chest pain)
- ☐ Artificial Heart Valve
- ☐ Heart Conditions
- ☐ Heart Surgery
- ☐ High/Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke

Cancer: Type _____
- ☐ Chemotherapy
- ☐ Radiation Therapy

Endocrinology
- ☐ Diabetes
- ☐ Hepatitis A/B/C
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Thyroid Disease

Gastrointestinal
- ☐ Ulcers (Stomach)
- ☐ Gastrointestinal Disease

Viral Infections
- ☐ AIDS
- ☐ HIV Positive
- ☐ HPV

Respiratory
- ☐ Asthma
- ☐ Emphysema
- ☐ Respiratory Problems
- ☐ Sinus Problems
- ☐ Sleep Apnea
- ☐ Tuberculosis

Hematologic/Lymphatic
- ☐ Anemia
- ☐ Blood Disorders
- ☐ Bruise Easily
- ☐ Excessive Bleeding

Women
- ☐ Currently Pregnant
- ☐ Nursing

Musculoskeletal
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Jaw Joint Pain
- ☐ Rheumatoid Arthritis

Neurological
- ☐ Anxiety
- ☐ Depression
- ☐ Dizziness
- ☐ Drug/Alcohol Addiction
- ☐ Fainting
- ☐ Seizures
- ☐ Psychiatric Illness

Are you under the care of a physician? ☐ ☐ yes, please explain _____
Physician Name _____ Address: _____ Phone(_____) _____
Have you had a serious illness, operation, or hospitalization in the past 5 years? Y or N, If yes please explain _____

Are you taking or have you recently taken any prescription or over the counter medicine(s)? Y or N If yes, please list all and why, including vitamins, natural or herbal supplements and/or dietary supplements _____

List all Medications or Substitutes you are Allergic to: _____

Have you ever in the past, or are you now currently taking any medications for Osteopenia/Osteoporosis or Bone Disease? If so, please list medications: _____

Have you ever had surgery? If so, what type: _____

Consent:

The undersigned hereby authorizes Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read, understand and agree t the above terms and conditions.

Signature of Patient/Legal guardian **Date** **Dentist Signature**

For completion by dentist only | Additional Comments