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PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

Patient's Name _____ Date _____

Last First Middle Preferred

Patient's Birthdate ____/____/____ Social Security Number _____ - _____ - _____

SINGLE___ MARRIED ___SEPARATED___DIVORCED___WIDOWED___

Home Address _____

Street City State Zip

Home Telephone _____ Work Telephone _____ Cell Phone _____

Preferred contact method(s) (please circle): Home / Cell / Work/Email E-mail Address: _____

Patient's Occupation _____ Patient's Employer _____

Business Address _____

Who may we thank for recommending you to our practice? _____

Spouse or Parent's Name (if patient is a minor) _____

Last Middle First Preferred

Spouse or Parent's Birthdate: ____/____/____ Spouse or Parents Contact Number(s)_ _____

Spouse or Parent's Occupation _____ Employer _____

In case of an Emergency, please contact _____

Home Phone _____ Cell Phone _____ Work Phone _____

Who is responsible for this account? _____

DENTAL INSURANCE

PRIMARY COVERAGE

Employee Name _____
Employee Date of Birth _____
Employer Insurance Company _____
Policy/ Member ID No. _____
Group No. _____
Ins. Company Phone No. _____

SECONDARY COVERAGE

Employee Name _____
Employee Date of Birth _____
Employer Insurance Company _____
Policy/Member ID No. _____
Group. No. _____
Ins. Company Phone No. _____

Form continues onto the back

Office Guidelines

Dental Insurance: Please note the following:

- Dental insurance is a contract between your Employer and the Insurance Company to assist you in meeting dental financial obligations. Your employer chooses the plan and the benefit level; it is not based upon treatment needed.
- Dental insurance is an aid and is NOT designed to cover all treatment costs.
- Most plans are written to cover only minimal care; please be aware that some, or perhaps all, of the services provided by our office may not be covered by your dental insurance company.

Financial Arrangements: Financial arrangements will be made prior to treatment. We accept cash, check, Visa, American Express, MasterCard, and Discover for your convenience. In addition, we offer payment plan options through Care Credit as well as Compassionate Finance upon approval. Past Due balances of 30 days or more will be charged an additional 1.5% monthly (18% APR).
Broken Appointment Policy: Your appointment has been reserved specifically for you. If you are unable to keep this appointed time we ask for 48 hours' notice so that we may use this appointment for another patient. Consistent broken appointments, late arrival (requiring rescheduling), and appointments cancelled with less than 48 hours' notice may necessitate a broken appointment fee ($36 per hour for duration of appointment length) or our office being unable to reschedule you or continue with your treatment.
Notice of Privacy Practices: A copy of our Privacy Practices is included in your new patient forms. The practice reserves the right to change the terms of its Notice of Privacy Practices and to make provisions effective for all protected health information that it maintains. By signing below; you acknowledge that you obtained this practice's current Notice of Privacy Practices and may request a copy at any time.

The information I have provided is complete and accurate to the best of my knowledge. I consent to whatever procedures are deemed necessary to diagnose my oral condition. I agree to be responsible for payment of all services rendered. I authorize a credit check should I ask for a credit. I acknowledge that I have read and understand the Office Guidelines.

Patient's Signature: _____ Today's Date: _____
Relationship to patient (if signed by a personal representative of patient)

Medical History Form

Name (Last)_____(MI)_____(First)_____(Prefered)_____

Date of Birth____/____/_____ Sex: (Male) (Female) Today's Date_____

For the following questions, circle Yes or No. Your answers are for our records only, answers will be considered confidential. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

1. Are you in good health? Yes No
2. Has there been any change in your general health in the past year? Yes No
3. My last physical examination was on?_____
4. Are you under the care of a physician now? Yes No
   If so, what is the condition you are being treated for?_____
5. The name and address of my physician(s) is_____
   _____
   _____
6. Have you had any serious illness, operation, or been hospitalized in the past 5 years? Yes No
   If so, what was the illness or problem?_____
7. Are you taking any medicine(s) including non-prescription medicine? Yes No
   If so what medicine(s) are you taking?_____
8. Have you ever been treated for alcohol or chemical dependency? Yes No
9. Do you currently smoke or use smokeless tobacco products? Yes No
   If yes, how many packs/times per day? _____ For how many years?_____
   If former smoker, when did you quit?_____
10. Do you have or have you had any of the following diseases or problems?
    a. Damaged heart valves or artificial valves, including heart murmur or rheumatic heart disease Yes No
    b. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke) Yes No
       1. Do you have inborn heart defect? Yes No
       2. Do you have a cardiac pacemaker? Yes No
       3. Have you ever taken Redux or Phen Phen? Yes No

c. Allergies	Yes	No	n. Kidney trouble	Yes	No
d. Sinus trouble	Yes	No	o. Tuberculosis	Yes	No
e. Asthma	Yes	No	p. Persistent cough or cough that produces blood	Yes	No
f. Seizures	Yes	No	q. Persistent swollen glands in neck	Yes	No
g. Diabetes	Yes	No	r. Low blood pressure	Yes	No
h. Hepatitis, jaundice or liver disease	Yes	No	s. Sexually transmitted diseases	Yes	No
i. AIDS or HIV infection	Yes	No	t. Epilepsy or other neurological disease	Yes	No
j. Thyroid problems	Yes	No	u. Problems with mental health	Yes	No
k. Respiratory problems, emphysema, Bronchitis, etc.	Yes	No	v. Cancer	Yes	No
l. Arthritis or painful swollen joints	Yes	No	w. Problems of the immune system	Yes	No
m. Stomach ulcer or hypersacidity	Yes	No	x. Had any lesions or growths in mouth	Yes	No

11. Have you had abnormal bleeding? Yes No
    a. Have you ever required a blood transfusion? Yes No
12. Do you have any blood disorders such as anemia? Yes No
13. Have you ever had any treatment for a tumor or growth? Yes No

14. Are you allergic or have you had a reaction to:

a. Local anesthetics	Yes	No	f. Iodine	Yes	No
b. Penicillin or other antibiotics	Yes	No	g. Codeine or other narcotics	Yes	No
c. Sulfa drugs	Yes	No	h. Latex	Yes	No
d. Barbiturates, sedatives, or Sleeping pills	Yes	No	i. Other		
e. Aspirin	Yes	No			

15. Have you had any serious trouble associated with any previous dental treatment? Yes No
    If yes, explain_____
    _____
16. Do you have any disease, condition, or problem not listed above that you think I should know about?
    _____
    _____
17. Are you wearing contact lenses? Yes No
18. Are you wearing removable dental appliances (such as a flipper, partial, denture etc.?) Yes No
19. Do you snore? Yes No
20. Do you wake up tired? Yes No

    If you answered yes to #19 and #20: These are the two most common symptoms of sleep apnea. Untreated sleep apnea raises your risk of serious health issues which can include: High blood pressure, stroke, heart disease, diabetes, chronic acid reflux, and erectile dysfunction. Ask us how a dental appliance may help.

Women

21. Are you pregnant? Yes No
    If yes, how far along? _____
22. Do you have any problems associated with your menstrual period? Yes No
23. Are you nursing? Yes No
24. Are you taking birth control (pills, shot, patch etc.?) Yes No

Notice to all patients: Per a new standard of care for our office, each patient will receive the VELscope screening once a year. Per office policy there is a $36 per hour scheduled for missed appointments.

Chief Dental Complaint _____

For confidential purposes, upon confirming appointments may we leave a message at home? Yes No (circle one) at work? Yes No (circle one)

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquires set forth have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form. **Patient Signature**_____ **Date**_____

OFFICE USE ONLY:

Dentist Signature_____ Date _____