



PATIENT REGISTRATION

ID: _____ Chart ID: _____

First Name: _____ Last Name: _____ Middle Initial: _____

Patient Is: ☐ Policy Holder

Preferred Name: _____

☐ Responsible Party

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ State / Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic: _____

E-mail: _____ ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

Section 3

CELL PHONE#: _____

Why did you select our office?

Whom may we thank for referring you?

Is another member of your family or relative a patient in our practice? _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Rem. Benefits: _____ .00 Rem. Deduct: _____ .00

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Rem. Benefits: _____ .00 Rem. Deduct: _____ .00

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ☐ Yes ☐ No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ☐ Yes ☐ No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No _____

Are you on a special diet? ☐ Yes ☐ No _____

Do you use tobacco? ☐ Yes ☐ No _____

Do you use controlled substances? ☐ Yes ☐ No _____

Women: Are you

Pregnant/Trying to get pregnant? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ☐ Yes ☐ No	Cortisone Medicine ☐ Yes ☐ No	Hemophilia ☐ Yes ☐ No	Renal Dialysis ☐ Yes ☐ No
Alzheimer's Disease ☐ Yes ☐ No	Diabetes ☐ Yes ☐ No	Hepatitis A ☐ Yes ☐ No	Rheumatic Fever ☐ Yes ☐ No
Anaphylaxis ☐ Yes ☐ No	Drug Addiction ☐ Yes ☐ No	Hepatitis B or C ☐ Yes ☐ No	Rheumatism ☐ Yes ☐ No
Anemia ☐ Yes ☐ No	Easily Winded ☐ Yes ☐ No	Herpes ☐ Yes ☐ No	Scarlet Fever ☐ Yes ☐ No
Angina ☐ Yes ☐ No	Emphysema ☐ Yes ☐ No	High Blood Pressure ☐ Yes ☐ No	Shingles ☐ Yes ☐ No
Arthritis/Gout ☐ Yes ☐ No	Epilepsy or Seizures ☐ Yes ☐ No	Hives or Rash ☐ Yes ☐ No	Sickle Cell Disease ☐ Yes ☐ No
Artificial Heart Valve ☐ Yes ☐ No	Excessive Bleeding ☐ Yes ☐ No	Hypoglycemia ☐ Yes ☐ No	Sinus Trouble ☐ Yes ☐ No
Artificial Joint ☐ Yes ☐ No	Excessive Thirst ☐ Yes ☐ No	Irregular Heartbeat ☐ Yes ☐ No	Spina Bifida ☐ Yes ☐ No
Asthma ☐ Yes ☐ No	Fainting Spells/Dizziness ☐ Yes ☐ No	Kidney Problems ☐ Yes ☐ No	Stomach/Intestinal Disease ☐ Yes ☐ No
Blood Disease ☐ Yes ☐ No	Frequent Cough ☐ Yes ☐ No	Leukemia ☐ Yes ☐ No	Stroke ☐ Yes ☐ No
Blood Transfusion ☐ Yes ☐ No	Frequent Diarrhea ☐ Yes ☐ No	Liver Disease ☐ Yes ☐ No	Swelling of Limbs ☐ Yes ☐ No
Breathing Problem ☐ Yes ☐ No	Frequent Headaches ☐ Yes ☐ No	Low Blood Pressure ☐ Yes ☐ No	Thyroid Disease ☐ Yes ☐ No
Bruise Easily ☐ Yes ☐ No	Genital Herpes ☐ Yes ☐ No	Lung Disease ☐ Yes ☐ No	Tonsillitis ☐ Yes ☐ No
Cancer ☐ Yes ☐ No	Glaucoma ☐ Yes ☐ No	Mitral Valve Prolapse ☐ Yes ☐ No	Tuberculosis ☐ Yes ☐ No
Chemotherapy ☐ Yes ☐ No	Hay Fever ☐ Yes ☐ No	Pain in Jaw Joints ☐ Yes ☐ No	Tumors or Growths ☐ Yes ☐ No
Chest Pains ☐ Yes ☐ No	Heart Attack/Failure ☐ Yes ☐ No	Parathyroid Disease ☐ Yes ☐ No	Ulcers ☐ Yes ☐ No
Cold Sores/Fever Blisters ☐ Yes ☐ No	Heart Murmur ☐ Yes ☐ No	Psychiatric Care ☐ Yes ☐ No	Venereal Disease ☐ Yes ☐ No
Congenital Heart Disorder ☐ Yes ☐ No	Heart Pace Maker ☐ Yes ☐ No	Radiation Treatments ☐ Yes ☐ No	Yellow Jaundice ☐ Yes ☐ No
Convulsions ☐ Yes ☐ No	Heart Trouble/Disease ☐ Yes ☐ No	Recent Weight Loss ☐ Yes ☐ No	

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes, please explain: _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

OFFICE POLICIES

Thank you for choosing our office to provide your dental care. We appreciate your trust and look forward to working with you. In order to prevent any misunderstanding and to better serve you, we ask that all patients read and sign our OFFICE POLICIES. If you have any questions, please ask the front desk.

1. **VERIFYING INSURANCE:** As a courtesy to you, we will verify your insurance for eligibility benefits prior to your new patient appointment as well as any time that you notify us of a change in your coverage. The insurance companies do not guarantee payment based on the information that they provide us. You are ultimately responsible for knowing if there are any waiting periods for work to be performed. Any amounts on your treatment plans that are not covered by your insurance, are your financial responsibility.
2. **PAYMENT:** Payment is due at the time of service. Additionally, if you have a balance following an insurance payment from a previous visit, you will be expected to pay that amount as well.
3. **INSURANCE INFORMATION:** New Insurance as well as changes in INSURANCE must be provided to this office prior to an appointment. Failure to provide correct and current insurance information may result in the entire bill being your responsibility.
4. **CHANGES IN PERSONAL INFORMATION:** Changes in your address or telephone numbers should be kept current with our office.
5. **REQUESTS FOR ADDITIONAL INFORMATION:** These must be responded to immediately. Such requests include proof of a college student's full-time status and proof of continued enrollment in an insurance plan. Failure to provide this information to the insurance company in a timely manner may result in the entire balance being your responsibility.
6. **PAYMENT PLANS:** Our office offers Third Party Financing if needed to assist you in paying for any necessary treatment.
7. **BALANCES:** If your account balance exceeds 30 days, you will receive a notice informing you that your account is overdue. If you do not pay your balance or arrange a payment plan within 10 days, your account will be turned over to a collections agency. If this happens, a collection fee (currently 39% of the balance) will be added to your account balance. The collection agency will report any unpaid balance to the major credit bureaus.
8. **RETURNED CHECKS:** There will be a \$30 fee for all returned checks. The amount of the check plus the fee must be paid within 10 days of notification by money order, cash or credit card. Once a check has been returned, this office will no longer accept personal checks for payment.
9. **CANCELLATIONS / FAILED APPOINTMENTS:** We request 24-hours notice if you are cancelling an appointment. There will be a \$50 fee for cancellations made without 24 hours notice and for failed appointments ("no shows"). The \$50 will be posted to your account, and you will not be allowed to make any other appointments for yourself or your family members until it is paid in full.

*** Thank you for reading this information in full. Please sign below to acknowledge your understanding of the OFFICE POLICIES ***

Patient or Guardian Signature _____ Date _____

Patient Name (Please Print) _____



Consent for Services

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I have read and understand the HIPAA policy.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

☐ I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent, or guardian (responsible party):

Signature: _____

Date: _____

Relationship to Patient:

Consent for Internet Communications

Patient Name:
Last First MI Preferred Name

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or any other need to deactivate my ID due to security concerns.

How would you like to be notified of your upcoming appointments?

_____ Phone _____

_____ Text Message (cell #) _____

_____ E-mail _____

We are so pleased that you chose our office
for your dental needs. Please let us know
how you heard about us:

_____ Referral from _____

_____ Radio _____ Billboard _____ Web-site

_____ Angie's List _____ Groupon _____ Google

_____ Movie Theater _____ Yelp _____ Yellow Pages



Take a few moments to tell us about your smile.	Yes	No
Do you like the appearance of your smile?		
Do you like the appearance of your teeth?		
Do you like the color of your teeth?		
Do you have spaces between your teeth that you don't like?		
Are there old fillings or dental work you don't like looking at?		
Have you had orthodontic work in the past?		
Are you aware that most dental insurance plans cover orthodontic treatments which include clear aligners?		
What would you change about your teeth? (Circle all that apply) Color Shape Size Straighten Other:		



Medical Information Release Form
(HIPPA Release Form)

Name: _____ Date of Birth: ____/____/____

Release of Information

() I authorize the release of information, including diagnosis, records, examinations rendered to me and claims information. This information may be released to:

- () Spouse: _____
- () Child(ren): _____
- () Other: _____

() Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call: () my home () my work () my cell _____

If unable to reach me:

- () You may leave a detailed message.
- () Please leave a message asking me to return your call
- () Other: _____

The best time to reach me is (morning/afternoon) between (time) _____

Signed: _____ Date: _____

Witness: _____ Date: _____



Our Practice continually looks for advances to ensure that we are providing the optimum level of oral health care to our patients. We are concerned about oral cancer and look for it in every patient.

One American dies every hour from oral cancer. Late detection of oral cancer is the primary cause that both the incidence and mortality rates of oral cancer continue to increase. As with most cancers, age is the primary risk factor for oral cancer. Tobacco and alcohol use are the other major predisposing risk factors, but more than 25% of oral cancer victims have no such lifestyle with using these risk factors. Oral cancer risk factors are as follows:

Increased risk: *patients 18-39*

-sexually active patients (HPV)

High risk: *patients age 40 and older; tobacco users (any age, any type within 10 years)*

Highest risk: *patients age 40 and older with lifestyles consisting of using tobacco and/or alcohol*

We have recently incorporated Velscope into our oral screening exam. We find that using the Velscope during the oral cancer examination improves our ability to identify suspicious areas at their earliest stages. Velscope is similar to early detection procedures for other cancers such as Mammography, Pap smear, and PSA (used in prostate examinations).

This advanced examination is recognized by the American Dental Association; however, this exam may not be covered by your dental insurance. The fee for this advanced examination is:

\$45 once a year

YES. I authorize the clinician to perform oral cancer detection with the use of the Velscope. I accept financial responsibility for this examination.

Print Name: _____

Signature: _____ Date: _____

NO. I would prefer not to have the Velscope used at this time. I do however understand the benefits of using this during my examination.

Print Name: _____

Signature: _____ Date: _____

Oral Cancer Screening Form