



REGISTRATION

Patient Name (Last, First, Middle): _____ Title: _____

Preferred Name _____ Gender: M / F Marital Status: S / M / D / W Birthdate: ____ / ____ / ____

SS #: _____ - _____ - _____ Address: _____

Town: _____ State: _____ Zip: _____ E-Mail Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Would you like a Text Message appointment reminder? Yes / No Which office location do you prefer? _____

Employer: _____ Position: _____

PRIMARY DENTAL INSURANCE COVERAGE

Subscriber Name: _____ Relationship to Patient: _____

Address: _____ Town _____ State _____ Zip _____

SS # (Required): _____ - _____ - _____ Birthdate (Required): ____ / ____ / ____

Employer: _____ Work Phone: _____

Insurance Company: _____ Group #: _____ Employee ID#: _____

Please provide us with your insurance card so we may make a copy for our records.

SECONDARY DENTAL INSURANCE COVERAGE

Subscriber Name: _____ Relationship to Patient: _____

Address: _____ Town _____ State _____ Zip _____

SS # (Required): _____ - _____ - _____ Birthdate (Required): ____ / ____ / ____

Employer: _____ Work Phone: _____

Insurance Company: _____ Group #: _____ Employee ID#: _____

Whom may we thank for referring you? _____

Which family member is financially responsible for payment of this account? _____

* Office use: Billing Type: _____ Dr Pref: _____ Clinic ID: _____

- I authorize the practice to take all necessary diagnostics, including x-rays. I authorize the practice to treat my dental needs using anesthetics or medications if necessary and am fully aware that these may involve risks.
- I authorize appointment reminders such as voicemail messages, postcards, letters or e-mail confirmations.
- I assign all dental insurance benefits to which I am entitled to the extent permitted under my dental insurance policy(s) to the Dentist. This Form also authorizes this Practice to submit insurance claim forms and receive payment directly from the Insurance Carrier with the notation "SIGNATURE ON FILE." I authorize my Dentist(s) to release treatment records / x-rays or any other information deemed pertinent to my insurance carrier, staff, hospitals or other medical practices as necessary and / or requested.
- I agree to be responsible for payment of all services rendered to me or to my dependents.

Patient / Parent or Guardian Signature: _____ Date: _____

It is customary to pay for professional procedures when they are rendered unless other arrangements have been made in advance. Preferred method of payment Visa/MC/Disc/Amex Check Cash

Name: _____ DOB: _____



MEDICAL HISTORY/ALERTS:

Physician Name: _____ Are you currently under the care of a physician? Yes No

Please Explain: _____

Cardiologist Name: _____ Do you smoke or use tobacco in any other form? Yes No

Hospitalized for Any Reason in last ____ years- Explain: _____

For Women:

Are you taking birth control pills? Yes No Are you pregnant? Yes No Week # ____ Nursing? Yes No

Have you ever had any of the following? (Please circle option that applies)

- | | |
|-----------------------------------------------|---------------------------------------|
| Y N Alcoholism/Drug Addiction | Y N Hearing Problems |
| Y N Anemia | Y N Hemophilia/Abnormal Bleeding |
| Y N Artificial Bone/Joints/Valves | Y N Hepatitis/ Type _____ |
| Y N Arthritis | Y N High Blood Pressure |
| Y N Asthma | Y N Low Blood Pressure |
| Y N Blood Transfusion | Y N HIV+/AIDS |
| Y N Cancer/Chemotherapy/Radiation Treatment | Y N Stomach Problems/Acid Reflux/GERD |
| Y N C-Dif | Y N Kidney Problems |
| Y N Congenital Heart Defect | Y N MRSA |
| Y N Diabetes | Y N Anxiety or Mood Disorder |
| Y N Difficulty Breathing/ Lung Problems | Y N Rheumatic/Scarlet Fever |
| Y N Emphysema/ Glaucoma | Y N STD/HPV/Other Infectious Disease |
| Y N Epilepsy/Seizures/Fainting Spells | Y N Shingles |
| Y N Fever Blisters/ Herpes | Y N Sickle Cell Disease/Traits |
| Y N Heart Attack/Stroke | Y N Sinus Problems |
| Y N Heart Murmur/ Mitral Valve Prolapse | Y N Tuberculosis (TB)/ When? _____ |
| Y N Heart Surgery/Pacemaker | Y N Ulcers/Colitis |
| Y N Thyroid Problems/Adrenal/Pituitary | Y N |
| Y N Headaches, if YES, please describe: _____ | |

Please list any serious medical condition(s) that you have ever had: _____

MEDICATIONS:

Are you taking any prescriptions? Yes No Please list each one _____

Over- the- counter drugs? Yes No Please list each one: _____

Do you Pre-Medicate for Dental Treatment? Yes No If yes, for what reason? _____

Have you even taken Bisphosphonates? Yes No If yes, when? _____

(Boniva-Fosamax-Actonel-Skelif-Diaconel-Aredia-Zometa)

ALLERGIES:

Are you allergic to any of the following?

- | | | | |
|----------------|------------------------|-------------------|------------------|
| Y N Aspirin | Y N Latex | Y N Jewelry/Metal | Y N Codeine |
| Y N Penicillin | Y N Dental Anesthetics | Y N Tetracycline | Y N Erythromycin |

Do you have sensitivity to dental anesthetic (Novocain)? Yes No

Please list any other drugs/materials that you are allergic to: _____

Name: _____ DOB: _____

DENTAL HISTORY:

Previous Dentist Name: _____

What brings you to see us today? _____

Do you snore? Y / N Do your gums ever bleed? Y/ N Have you ever had braces? Y/N

Orthodontist Name: _____ When? _____ Have you ever whitened your teeth? Y/N

Do you ever have jaw pain Y/N Does your jaw click or pop Y/N Have you had wisdom teeth removed? Y/N

Have you ever had Botox/facial filler? Y/N Have you ever had a serious/difficult problem associated with any previous dental work? Y/ N *If yes, please explain:* _____

If you could change one thing about your smile, what would it be? _____

Acknowledgement of Receipt of Notice of Privacy Practices (HIPAA)

I, _____, have received a copy of this office’s “Notice of Privacy Practice”

Signature of Patient or parent/guardian

Date

1. _____
Name(s) of individuals to whom we may disclose your PHI

2. _____
Name(s) of individuals to whom we may disclose your PHI

3. _____
Name(s) of individuals to whom we may disclose your PHI

FOR OFFICE USE ONLY
We attempted to obtain a written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please specify)

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature _____

Date _____



Financial Policy

Our commitment to you is to provide a patient centered experience each time you visit us. We desire to work with patients who are invested in their care and take responsibility for their own health. We will do our best to educate you about your needs and options to assist you in making your own choices regarding your dental treatment.

With our vision for you in mind we are happy to file insurance claims, work to maximize your benefit plans on your behalf and submit pre-estimates for certain procedures. **However, the ultimate responsibility of the fees for all dental treatment remains with you, our patient.**

Each patient case is unique and we make every attempt to work with you as an individual to customize a treatment plan and financial arrangements that you are comfortable with.

It is customary to pay for all dental treatment at the time of your visit. Any other arrangements must be made in advance.

- You may pay your portion at the time of your visit using cash, check, Visa, MasterCard, Discover or American Express.
- Arrangements may be made in advance for interest free financing through Care Credit and Citi Health options.
- For those patients who have insurance benefits, we will estimate the portion we anticipate is not covered by insurance and will inform you of your expected co-payment. **Please keep in mind these are not guarantees of your insurance payment but estimates only.**
- You may set up automatic credit card payments for pre-arranged installment plans.

PLEASE RETAIN THIS COPY

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