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