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Welcome to our Practice!

Patient Name: _____ _____ ____ _____
Last First MI Preferred Name

Title: _____ **Gender:** __ Male __ Female __ Other **Family Status:** __ Married __ Single __Child __ Other
Mr/Ms/Mrs/Dr/et

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Date of Birth: _____ **SS#:** _____

Email Address: _____ **Cell Phone #:** _____

Responsible Party Information

- If the Patient is the responsible party, skip this section and continue to the next section

Patient Name: _____ _____ ____ _____
Last First MI Preferred Name

Title: _____ **Gender:** __ Male __ Female __ Other **Family Status:** __ Married __ Single __Child __ Other
Mr/Ms/Mrs/Dr/et

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Date of Birth: _____ **SS#:** _____

Email Address: _____ **Cell Phone #:** _____

Primary Dental Insurance

Patient's relationship to insured: ___ Self ___ Spouse ___ Child ___ Other

Subscriber's Name: _____ _____ **Date of Birth:** _____
Last First

Insurance Carrier: _____ **Insured Employed By:** _____

Insurance Group #: _____ **Subscriber's I.D #:** _____

Insurance Carrier's Address: _____

_____

Secondary Dental Insurance

Patient's relationship to insured: ___ Spouse ___ Child ___ Other

Subscriber's Name: _____ _____ **Date of Birth:** _____
Last First

Insurance Carrier: _____ **Insured Employed By:** _____

Insurance Group #: _____ **Subscriber's I.D #:** _____

Insurance Carrier's Address: _____

_____

- **Insurance Subscriber information if the subscriber is a 3rd party to this registration form.**

Name: _____ _____ _____ **Title:** _____
Last First MI Mr/ Ms/ Mrs/ Dr/etc

Gender: __ Male __ Female __ Other **Relationship to Patient:** ___ Parent ___ Other

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Date of Birth: _____ **SS#:** _____

Email Address: _____ **Cell Phone #:** _____

Medical & Dental History Form

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well-being.

Would you consider yourself to be in fairly good health? ____ Yes ___ No

Within the past year, have there been any changes in your general health? ___ Yes ___ No

Please mark any of the following to indicate Yes in response to the question:

☐ Have you ever had complications following dental treatment?

☐ Are you currently under the care of a physician due to a surgery or illness?

☐ Have you been hospitalized within the last 5 years due to surgery or illness?

☐ Are you currently taking any prescription or non-prescription medication?

☐ Do you use tobacco (smoking or chewing)?

☐ *Pre-Med – Amox	☐ *Pre-Med – Ceph	☐ *Pre-Med – Clind	☐ Allergic to Keflex
☐ Allergic to Penicill	☐ Allergies	☐ Allergy – Aspirin	☐ Allergy – Cephalexin
☐ Allergy – Codeine	☐ Allergy – Erythro	☐ Allergy – Hay Fever	☐ Allergy – Latex
☐ Allergy – Other	☐ Allergy – Penicillin	☐ Allergy – Sulfa	☐ Anemia
☐ Arthritis	☐ Artificial Joints	☐ Asthma	☐ Blood Disease
☐ Cancer	☐ Diabetes	☐ Dizziness	☐ Epilepsy
☐ Excessive Bleeding	☐ Fainting	☐ Glaucoma	☐ Head Injuries
☐ Heart Disease	☐ Heart Murmur	☐ Hepatitis	☐ High Blood Pressure
☐ HIV	☐ Jaundice	☐ Kidney Disease	☐ Liver Disease
☐ Mental Disorders	☐ Nervous Disorders	☐ Other	☐ Pacemaker
☐ Pregnancy	☐ Radiation Treatment	☐ Respiratory Problems	☐ Rheumatic Fever
☐ Rheumatism	☐ Sinus Problems	☐ Stomach Problems	☐ Stroke
☐ Tuberculosis	☐ Tumors	☐ Ulcers	☐ Venereal Disease

☐ Do you have any other conditions, diseases, etc., not listed that we should be aware of?

If any of the previous questions were marked, please explain:

_____

_____

_____

Are you Pregnant? _____ Yes ____ No ____ Unsure

When is your due date? _____

Please list any medications you are currently taking (or attach a list if necessary):

_____

_____

_____

_____

Do you have any other health issues or allergies?

_____

_____

_____

_____

What is the reason for your dental visit today?

_____

_____

When was your last visit to the dentist (if to a different office)?

_____

_____

What was done on your last dental visit (if at a different office)?

_____

_____

How frequently do you brush your teeth?

◯ 3 (+) a day ◯ Twice a day ◯ Once a day ◯ Weekly ◯ Seldom

How frequently do you floss your teeth?

◯ 1 (+) a day ◯ 2 - 6 weekly ◯ 1 - 6 monthly ◯ Seldom ◯ Never

Please mark any of the following to indicate Yes in response to the question:

☐ Do your gums bleed when you brush or floss?

☐ Do your teeth experience sensitivity to hot or cold temperatures?

☐ Are any of your teeth causing you pain?

☐ Are any of your teeth loose or are you concerned about any teeth?

☐ Do you currently have any dental implants, dentures or partials?

If you could, is there anything you would like to change about your teeth or smile? If so, please explain:

_____

_____

_____

☐ **To the best of my knowledge, all of the preceding information is true and correct. If I everhave a change in my teeth, I will inform the office at my next dental appointment without fail. By checking the box, this will serve as my signature for the Administration Form.**

PRACTICE POLICIES

PLEASE read this carefully and ask questions about any concerns you may have BEFORE treatment is rendered. Submission to treatment implies consent to the terms of this agreement.

TREATMENT: I am dedicated to helping you improve your dental health as quickly as possible. Every effort will be made to make your appointment as comfortable and pleasant as possible. Please feel free to discuss your treatment with me at any time.

INSURANCE: We submit all insurance claims requesting assignment of benefits to be paid to us, unless told otherwise. Any balance not covered by your insurance is still owed by the patient or responsible person. However, not all carriers will reimburse us directly. If that is the case, payment will be due at the time of serviced unless other arrangements are made first. We make no guarantee of any payment by your insurance carrier.

APPOINTMENTS: When we schedule your appointment, my time is reserved exclusively for you. When patients fail to notify us of their inability to keep an appointment, another patient in need of dentistry is unable to receive treatment. We request that you give us at least 24 hours notice when an appointment cannot be kept. When a notice is not given, a fee of $50.00 per half hour will be charged.

CREDIT: When credit is extended, which occurs when payment is not rendered in full at the time of service regardless of insurance, we will require your social security number to be placed on file. The only way to avoid this is to pay in full at the time of service. First time appointments that are for emergency exams, consultations or second opinions, payment must be made in full regardless of insurance

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,

Please list authorized persons with whom we may discuss your Protected Health Information (PHI) in addition to custodial parents and legal guardians: (example: John Doe (212-555-1212)

_____

_____

☐ By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.

Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that
providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party
insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental
practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

_____ **Date:**_____

Signature of patient, parent, or guardian:

_____

Relationship to Patient: