Dental Registration and History

1 PATIENT INFORMATION

Date_____

SS#/Patient ID#_____

Patient Name_____
Last Name

_____
First Name Middle Initial

Address_____

City_____

State_____ Zip _____

E-mail_____

Sex ☐ M ☐ F Age_____

Birthdate_____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Employer/School Phone _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you?

_____

2 DENTAL INSURANCE

Who is responsible for this account?_____

Relationship to Patient_____

Insurance Company_____

Group #_____

Is patient covered under additional insurance? ☐ Yes ☐ No

Subscriber's name_____

Birthdate_____ SS#_____

Relationship to Patient_____

Insurance Company_____

Group#_____

3 PHONE NUMBERS

Home (____)_____ Cell (____)_____

Work (____)_____ ext _____

Spouse's Work (____)_____ ext _____

Best Time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (specify someone who does not live in your household).

Name _____

Relationship _____

Home (____)_____ Cell (____)_____

Work (____)_____ ext_____

Preferred Pharmacy _____

Pharmacy Phone (____)_____

4 DENTAL HISTORY

Reason for today's visit _____ Former Dentist_____

City/State _____ Date of last dental visit_____ Date of last dental x-rays_____

Place a mark on "yes" or "no" to indicate if you have had any of the following.

	Yes	No		Yes	No		Yes	No
Bad breath	☐	☐	Gums swollen or tender	☐	☐	Sensitivity when biting	☐	☐
Bleeding gums	☐	☐	Jaw pain or clicking or popping	☐	☐	Sore muscles of face	☐	☐
Blisters on lips or mouth	☐	☐	Pain around ear	☐	☐	Sores or growths in your mouth	☐	☐
Broken fillings or teeth	☐	☐	Loose teeth	☐	☐	Nervous about seeing a dentist	☐	☐
Chew on one side of mouth	☐	☐	Orthodontic treatment	☐	☐	Wear partials or dentures	☐	☐
Dental implants	☐	☐	Periodontal treatment	☐	☐	Would you like nitrous oxide ?	☐	☐
Dry Mouth	☐	☐	Sensitivity to cold	☐	☐	How often do you floss? _____	per day	
Food collecting between teeth	☐	☐	Sensitivity to heat	☐	☐	How often do you brush? _____	per day	
Grind or clench teeth	☐	☐	Sensitivity to sweets	☐	☐			

TURN OVER

Dental Registration and History

5 HEALTH HISTORY

Physician's Name / Office #_____ Date of last visit_____

Have you ever taken any of the group of drugs collectively referred to as : Yes No

1) "fen-phen" these include combinations of Ionimin, Adipex, Fastin (phentermine), Pondimin (fenfluramine) ☐ ☐
2) Bisphosphonates for bone loss or osteoporosis – Boniva, Fosamax, Evista, Etc. ☐ ☐

Place a mark on "yes" or "no" to indicate if you have had any of the following.

	Yes	No
AIDS/HIV	☐	☐
Alcohol intolerance	☐	☐
Anemia	☐	☐
Arthritis, Rheumatism	☐	☐
Artificial heart valves	☐	☐
Artificial joints	☐	☐
Date of surgery _____		
Asthma or Hay Fever	☐	☐
Back problems	☐	☐
Bleeding abnormally, with extractions or surgery	☐	☐
Blood disease	☐	☐
Cancer	☐	☐
Chemical dependency	☐	☐
Chemotherapy	☐	☐
Circulatory problems	☐	☐
Congenital heart lesions	☐	☐
Cortisone treatments	☐	☐
Cough, persistent or bloody	☐	☐

	Yes	No
Diabetes	☐	☐
Sugar level this morning _____		
Emphysema	☐	☐
Epilepsy	☐	☐
Fainting or dizziness	☐	☐
Head aches	☐	☐
Heart murmur	☐	☐
Heart problems	☐	☐
Hepatitis type _____	☐	☐
Herpes	☐	☐
High blood pressure	☐	☐
Jaw pain	☐	☐
Kidney disease	☐	☐
Liver disease	☐	☐
Low blood pressure	☐	☐
Mitral valve prolapse	☐	☐
Nervous problems	☐	☐
Neurological problems	☐	☐
Pacemaker or Defibrillator	☐	☐
Psychiatric care	☐	☐
Radiation Treatment	☐	☐

	Yes	No
Respiratory disease	☐	☐
Rheumatic fever	☐	☐
Scarlet fever	☐	☐
Seizures	☐	☐
Shortness of breath	☐	☐
Sinus trouble	☐	☐
Skin rash or hives	☐	☐
Stroke	☐	☐
Swollen neck glands	☐	☐
Thyroid problems	☐	☐
Tuberculosis	☐	☐
Tumor or growth	☐	☐
Ulcers	☐	☐
Venereal Disease	☐	☐
Weight loss, unexplained	☐	☐
X-ray exposure at work	☐	☐
Do you wear contact lenses?	☐	☐
WOMEN		
Pregnant? Due date _____	☐	☐
Are you nursing ?	☐	☐

6 MEDICATIONS

List any medications you are taking and why. _____

_____

_____

_____

ALLERGIES

☐ Aspirin ☐ Barbiturates ☐ Codeine ☐ Latex ☐ Local Anesthetic ☐ Penicillin ☐ Sulfa ☐ Ibuprofen

☐ Other _____

7 SIGNATURE

X _____ X _____ _____ _____

Signature (parent if minor) DATE Dr's initails date

Pro-Dental Care Financial and Appointment Policy

Welcome to Pro-Dental Care. We are here to provide our patients with the best possible dental care. As your provider, we recommend treatment that is in the best interest of your medical and dental health. Be aware that insurance companies select certain dental procedures that they may or may not cover regardless of your personal situation, health, and dental needs. The following is an overview of our office financial policy.

Insurance: Dental Insurance rarely pays for 100% of all dental services. As a courtesy, we will bill your dental insurance for your care, providing you give us the needed information for claim submission. Your estimated copays are due at time of service and any balance unpaid after the claim settles is due within 14 days of receipt of statement.

Initials_____

Payment from the insurance company is expected within thirty (30) days. If your insurance company has not responded within a sixty (60) days grace period from the date of service, the remaining balance in full is your responsibility. At the time of service, we will request from you an initial payment; this is an estimated portion of the charges which insurance may not cover, including all applicable deductibles and copays.

Initials_____

Payment: Payment in full is required at the time of service. For your convenience, we accept cash, checks, debit, and credit cards, including Visa, MasterCard and Discover. Our office also offers no interest and extended payment plans, upon approved credit, through CareCredit.

Initials_____

Estimates: Before treatment, we will perform a diagnosis and provide you with an estimate of the charges involved. As treatment progresses, it is possible that additional circumstances not be apparent at the initial exam, may be encountered. In this event, we will discuss options with you and proceed as necessary.

Initials_____

Aged Account: The total balance on your account, after claim settlement, is due upon receipt of statement. Failure to keep this account current may result in Pro-Dental Care being unable to provide additional dental services. In the event of a default, I agree that any information collected can be used to collect on my account, and I agree to pay all costs incurred in the attempt to collect on this account, including late fees of 10% or $30 (whichever is greater),
finance charges, service and/or collection agency fees, attorney's fees and court costs.

Initials_____

Appointments: If you are unable to keep a scheduled appointment, we ask that you provide us with 48-hour notice as a courtesy. Notice of less than 48 hours may result in a minimum charge of $50.00. We understand emergencies arise; we are sensitive to those events.

Initials_____

Patient Name: _____

Patient/ Guardian Signature: _____ Date _____

HIPAA Acknowledgement

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

-Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

-Obtain payment from third-party payers.

-Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information.

I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address to obtain a current copy of the Notice of Private Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Patient/ Guardian Signature: _____

Date: _____

Authorization to Disclose
Protected Health Information to Family and Friends

Release Information To Person Authorized to Receive Information (list one individual per form)

Name (First, Middle, Last)_____

Birth Date (mm-dd-yyyy): _____ Relationship to Patient: _____

The individual named above is authorized to obtain information in the following manner(s) (check all that apply):

- ☐ **Verbally:** for example, via phone, face-to-face.
- ☐ **Written or printed format:** for example, medical record copies or the patient appointment guide.
- ☐ **DECLINE:** _____

Patient Name: _____

Patient/Guardian Signature: _____

Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF INFORMATION

Notice of Privacy Practices:
I acknowledge I have received, read and understand the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information.

Initials _____

HIPAA:
I acknowledge I have received, read and understand the HIPAA Act.

Initials _____

FINANCIAL AND APPOINTMENT POLICY:
I acknowledge I have received, read and understand the Appointment and Financial Policy.

Initials _____

Authorization:

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including diagnosis/records of any treatment/examination rendered to me during the period of such dental care to third party payers/health practitioners. I authorize and request my insurance to pay directly to the dentist/dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants. I am aware of the missed appointment/cancellation fee. If I fail to speak to the office staff at least two business days prior to appointment.

Patient Name: _____

Patient/ Guardian Signature: _____

Date: _____