



NEW PATIENT REGISTRATION FORM

Welcome

Thank you for selecting our dental healthcare team! We will strive to provide you and your family with excellence in dental care. If you have any questions or need assistance, please ask us -we will be happy to help.

Please Print. In certain cases, as you complete this form you may find the information requested to be repetitive. Please leave the following information fields empty if you have provided them before. Thank you.

PATIENT INFORMATION: Date _____

Title _____ First Name _____ Last Name _____ MI _____

Birth date _____ SSN# _____ E-mail _____

Cell Phone _____ Home Phone _____ Work Phone _____

Address _____ City _____ State _____ Zip _____

Check Appropriate Box: Minor Single Married Divorced Widowed Separated

If Student, Name of School/College _____ City _____ State _____ Full Time Part Time

Spouse or Parent's: First Name _____ Last Name _____ MI _____ Work Phone _____

Person to contact in Case of Emergency _____ Phone _____

What kind of filling material would you like us to use: Tooth-Colored Silver-Colored (Please ask our staff if you have questions)

Are you interested in any cosmetic treatments to improve your smile? YES NO If YES, please let us know what you would like to know more about (teeth whitening options, smile makeovers options including veneers, teeth replacements, chips, cracks,

Whom May We Thank for Referring You? _____

RESPONSIBLE PARTY:

Name of Person Responsible for this Account _____ Relationship to Patient _____

SSN # _____ Birthdate _____ Driver's License # _____

Address _____ City _____ State _____ Zip _____

Employer _____ Work Phone _____

Is this Person Currently a Patient in our Office? Yes No

DENTAL INSURANCE:

Name of Primary Insured _____ Relationship to Patient _____

SSN# _____ Insurance ID#: _____ Birth-date _____ Date Employed _____

Name of Employer _____ Union or Local# _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Policy/ID # _____

PLEASE NOTE, FOR PATIENTS WITH DENTAL INSURANCE BENEFITS:

- All quotes for services provided at the time of treatment are ESTIMATES ONLY, including patient portions; along your dental benefit plan guidelines and any difference will be billed to you after reimbursements from your dental benefits company.
Most dental benefit plans do not fully reimburse tooth-colored fillings or crowns on posterior teeth but opt to reimburse less expensive alternative treatments such as silver fillings (Amalgams) and pass on the difference in cost to the patients.
Almost all dental benefit plans do not cover any treatments of a cosmetic nature.
As with many other dental practices, we do not file secondary insurance claims due to the conflict of contracts and agreements
Our doctors or staff cannot guarantee what your dental benefit plan covers or states. PATIENT INITIALS _____

Any treatment cost including your dental insurance out-of-pocket costs may be financed through CareCredit.

PLEASE LET US KNOW OF ANY INSURANCE OR MEDICATION CHANGES AT EVERY VISIT. Your health and well being is our primary concern.

MEDICAL & DENTAL HEALTH HISTORY

Patient's Name _____ Birth-date _____

Physician _____ Office Phone _____ Date of Last Exam _____

PATIENT'S MEDICAL HISTORY

| | Yes | No | | Yes | No | | Yes | No |
|---------------------------------|--------------------------|--------------------------|--------------------------------|--------------------------|--------------------------|-----------------------------------|--------------------------|--------------------------|
| Heart Ailment Name _____ | <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Respiratory Disease Name _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Murmur | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic Fever | <input type="checkbox"/> | <input type="checkbox"/> | Tumors/Growths | <input type="checkbox"/> | <input type="checkbox"/> |
| Mitral Valve Prolapse | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatism/Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Any Blood Disease Name _____ | <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease | <input type="checkbox"/> | <input type="checkbox"/> | HIV/Aids | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> | Venereal Disease Name _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Pacemaker | <input type="checkbox"/> | <input type="checkbox"/> | Seizures | <input type="checkbox"/> | <input type="checkbox"/> | Latex Allergy | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Artificial Joint Name _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | |

- | | Yes | No |
|---|--------------------------|--------------------------|
| 2. Are you under any medical treatment? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. List any medications you are taking. _____ _____ | | |
| 4. Have you ever had a bad reaction (hives, asthma) to any drugs, materials, or food? If yes, name _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have a history of alcohol abuse? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you have a history of drug abuse (crack/cocaine, amphetamines, heroin, other) _____ Name _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever taken Phenylenolamine or Redux? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you had any major operations? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you had a blood transfusion? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have any wounds healed slowly or presented other complications? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you ever had a serious accident involving head injuries? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you ever had chemotherapy or radiation treatment? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Are you pregnant? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Have you ever had an eating disorder (anorexia/bulimia)? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Do you smoke, use chewing tobacco or snuff? _____ | <input type="checkbox"/> | <input type="checkbox"/> |

PATIENT'S DENTAL HISTORY

- | | | |
|--|--------------------------|--------------------------|
| 1. Do you have any pain in or near your ears? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have any unhealed injuries or inflamed areas in or around your mouth? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you experienced any growths or sore spots in your mouth? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever had Novocain anesthetic? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Any difficult extractions in the past? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Prolonged bleeding following extraction in the past? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do your gums bleed? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you habitually clench your teeth during the day or night? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. When was your last full mouth set of x-rays taken _____ | | |
| 8. Is any part of your mouth sore to pressures or irritants (hot, cold, sweets, etc.)? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| If so locate _____ | | |

AUTHORIZATION AND RELEASE

*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 the diagnosis and the records of any treatment or examination rendered to me, or my child, during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. **I agree to be responsible for payment of all services rendered on my behalf or my dependents and that payment is required at the time of treatment. I certify that I have read and understand the above information to the best of my knowledge.***

PATIENT'S SIGNATURE (Or parent if minor) _____ Date _____

| | |
|--------------------------------|------------|
| Doctor's Comments _____ | |
| _____ Doctor's Signature _____ | Date _____ |