MOKTAN DENTAL CARE
Excellence in Dentistry
Family, Cosmetic & Implant

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.

IMPLANTS ► ROOT CANALS ►BRIDGES ► DENTURES ► CROWNS

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_____

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_____

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

DENTAL INSURANCE:

Primary Insured's Name_____ Relationship to Patient _____ SSN#/ID#_____ Birth-date _____

Employer Name_____ 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. We only use tooth-colored composite material for filings at our office.
- 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/staff CANNOT GUARANTEE what dental benefit plans cover or state.** ***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.

105 Coeway Lane, Exton, PA 19341 Phone (610) 363-7550 Fax (610) 363-7551

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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	☐	☐	High Blood Pressure	☐	☐	Respiratory Disease	☐	☐
Name_____			Rheumatic Fever	☐	☐	Name_____		
Heart Murmur	☐	☐	Rheumatism/Arthritis	☐	☐	Tumors/Growths	☐	☐
Mitral Valve Prolapse	☐	☐	Liver Disease	☐	☐	Kidney Disease	☐	☐
Any Blood Disease	☐	☐	Tuberculosis	☐	☐	HIV/Aids	☐	☐
Name_____			Seizures	☐	☐	Venereal Disease	☐	☐
Diabetes	☐	☐	Artificial Joint	☐	☐	Name_____		
Pacemaker	☐	☐	Name _____			Latex Allergy	☐	☐

	Yes	No
2. Are you under any medical treatment?_____	☐	☐
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_____		
5. Do you have a history of alcohol abuse?_____	☐	☐
6. Do you have a history of drug abuse (crack/cocaine, amphetamines, heroin, other)_____	☐	☐
Name_____		
7. Have you ever taken Phen Phen or Redux?_____	☐	☐
8. Have you had any major operations?_____	☐	☐
9. Have you had a blood transfusion?_____	☐	☐
10. Have any wounds healed slowly or presented other complications?_____	☐	☐
11. Have you ever had a serious accident involving head injuries?_____	☐	☐
12. Have you ever had chemotherapy or radiation treatment?_____	☐	☐
13. Are you pregnant?_____	☐	☐
14. Have you ever had an eating disorder (anorexia/bulimia)?_____	☐	☐
15. Do you smoke, use chewing tobacco or snuff?_____	☐	☐

PATIENT'S DENTAL HISTORY

1. Do you have any pain in or near your ears?_____	☐	☐
2. Do you have any unhealed injuries or inflamed areas in or around your mouth?_____	☐	☐
3. Have you experienced any growths or sore spots in your mouth?_____	☐	☐
4. Have you ever had Novocain anesthetic?_____	☐	☐
Any difficult extractions in the past?_____	☐	☐
Prolonged bleeding following extraction in the past?_____	☐	☐
5. Do your gums bleed?_____	☐	☐
6. Do you habitually clench your teeth during the day or night?_____	☐	☐
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.)?_____	☐	☐
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_____