PATIENT REGISTRATION

PATIENT INFORMATION:

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cell Phone: _____

Birthdate: _____ Social Security Number: _____ Email: _____

Sex: ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Employer: _____ Occupation: _____

Referred By: ☐ Family/Friend: _____ ☐ Google ☐ Facebook ☐ Mail Piece

☐ Yellow Pages ☐ Insurance Company ☐ Other: _____

Previous Dentist: _____

Emergency Contact: _____

Emergency Contact Phone Number: _____

Preferred Pharmacy: _____

Comments: _____

RESPONSIBLE PARTY: Patient is: ☐ Responsible Party

First Name: _____ Last Name: _____ Middle Initial: _____

Relation to patient: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cell Phone: _____

Birthdate: _____ Social Security Number: _____ Email: _____

Employer: _____ Occupation: _____

PRIMARY INSURANCE INFORMATION:

Dental Insurance Company: _____

ID Number/Member ID: _____

Policy Holder Name: _____

Policy Holder Birthdate: _____

Policy Holder's SSN: _____

Policy Holder's Employer: _____

Policy Holder's Address: _____

Policy Holder's Zip Code: _____

SECONDARY INSURANCE INFORMATION:

Dental Insurance Company: _____

ID Number/Member ID: _____

Policy Holder Name: _____

Policy Holder Birthdate: _____

Policy Holder's SSN: _____

Policy Holder's Employer: _____

Policy Holder's Address: _____

Policy Holder's Zip Code: _____

In Office Signatures:

I have read and understand the Notice of Privacy Practices and Authorization (HIPPA).

Signature: _____ Date: _____

Relationship to patient: _____

I give my consent to Dental Renaissance to notify/contact me via unencrypted email or text which may include personal health information. (ex: appointment reminders, notifications)

Signature: _____ Date: _____

Relationship to patient: _____

MEDICAL HISTORY

Patient Name: _____ Birthdate: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

If you answer yes to the following questions, please explain on the blank provided.	YES	NO
Are you under a physician's care now?	☐	☐
Have you ever been hospitalized or had a major operation?	☐	☐
Have you ever had a serious head or neck injury?	☐	☐
Are you taking any medications, pills, or drugs?	☐	☐
If yes, please provide a MED LIST:	☐	☐
Do you take, or have you taken Phen-Fen or Redux?	☐	☐
Have you ever taken Fosamax, Boniva, Actonel, or any other medication containing bisphosphonates?	☐	☐
Are you on a special diet?	☐	☐
Do you use tobacco?	☐	☐
Do you use controlled substances?	☐	☐

* Women, are you: (circle all that apply) Pregnant Trying to get pregnant Taking oral contraceptives Nursing

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthestics ☐ Acrylic ☐ Metal ☐ None
☐ Latex ☐ Sulfa Drugs ☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

	YES	NO		YES	NO		YES	NO		YES	NO
AIDS/HIV Positive	☐	☐	Cortisone Medicine	☐	☐	Hemophilia	☐	☐	Recent Weight Loss	☐	☐
Alzheimer's Disease	☐	☐	Diabetes	☐	☐	Hepatitis A	☐	☐	Renal Dialysis	☐	☐
Anaphylaxis	☐	☐	Drug Addiction	☐	☐	Hepatitis B or C	☐	☐	Rheumatic Fever	☐	☐
Anemia	☐	☐	Easily Winded	☐	☐	Herpes	☐	☐	Rheumatism	☐	☐
Angina	☐	☐	Emphysema	☐	☐	High Blood Pressure	☐	☐	Scarlet Fever	☐	☐
Arthritis/Gout	☐	☐	Epilepsy or Seizures	☐	☐	High Cholesterol	☐	☐	Shingles	☐	☐
Artificial Heart Valve	☐	☐	Excessive Bleeding	☐	☐	Hives or Rash	☐	☐	Sickle Cell Disease	☐	☐
Artificial Joint	☐	☐	Excessive Thirst	☐	☐	Hypoglycemia	☐	☐	Sinus Trouble	☐	☐
Asthma	☐	☐	Fainting Spells/Dizziness	☐	☐	Irregular Heartbeat	☐	☐	Spina Bifida	☐	☐
Blood Disease	☐	☐	Frequent Cough	☐	☐	Kidney Problems	☐	☐	Stomach/Intestinal	☐	☐
Blood Transfusion	☐	☐	Frequent Diarrhea	☐	☐	Leukemia	☐	☐	Disease		
Breathing Problem	☐	☐	Frequent Headaches	☐	☐	Liver Disease	☐	☐	Stroke	☐	☐
Bruise Easily	☐	☐	Genital Herpes	☐	☐	Low Blood Pressure	☐	☐	Swelling of Limbs	☐	☐
Cancer	☐	☐	Glaucoma	☐	☐	Lung Disease	☐	☐	Thyroid Disease	☐	☐
Chemotherapy	☐	☐	Hay Fever	☐	☐	Mitral Valve Prolapse	☐	☐	Tonsillitis	☐	☐
Chest Pains	☐	☐	Heart Attack/Failure	☐	☐	Osteoporosis	☐	☐	Tuberculosis	☐	☐
Cold Sores/Fever Blisters	☐	☐	Heart Murmur	☐	☐	Pain in Jaw Joints	☐	☐	Tumors or Growths	☐	☐
Congenital Heart Disorder	☐	☐	Heart Pacemaker	☐	☐	Parathyroid Disease	☐	☐	Ulcers	☐	☐
Convulsions	☐	☐	Heart Trouble/Disease	☐	☐	Psychiatric Care	☐	☐	Venereal Disease	☐	☐
						Radiation Treatments	☐	☐	Yellow Jaundice	☐	☐

Have you every had any serious illness not listed above? _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in my medical status.

Signature of Patient, Parent, or Guardian _____ Date: _____

Doctor Signature: _____ Date: _____

DENTAL HISTORY

Name: _____

How would you rate the condition of your mouth? Excellent Good Fair Poor

Previous Dentist: _____ How long have you been a patient? _____

Date of most recent dental exam: _____ Date of most recent x-rays:

Date of most recent treatment (other than cleaning): _____

I routinely see the dentist every: 3 months 4 months 6 months 12 months Not routinely

What is your immediate concern? _____

Please answer yes or no to the following:

Personal History

	YES	NO
1. Are you fearful of dental treatment? How fearful on a scale of 1 (least) to 10 (most)?	☐	☐
2. Have you had an unfavorable dental experience?	☐	☐
3. Have you had complications from past dental treatment?	☐	☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic?	☐	☐
5. Did you ever have braces, orthodontic treatment or have your bite adjusted?	☐	☐
6. Have you had any teeth removed?	☐	☐

Smile Characteristics

1. Is there anything about the appearance of your teeth you would like to change?	☐	☐
2. Have you ever whitened (bleached) your teeth?	☐	☐
3. Have you felt uncomfortable or self-conscious about the appearance of your teeth?	☐	☐
4. Have you been disappointed with the appearance of previous dental work?	☐	☐

Bite & Jaw Joint

1. Do you have problems with your jaw joint? (pain, sounds, limited opening, lock popping)	☐	☐
2. Do you/would you have any problems chewing gum?	☐	☐
3. Do you/would you have any problems chewing bagels, baguettes, protien bars, or, other hard foods?	☐	☐
4. Have your teeth changed in the last 5 years, become shorter, thinner or worn?	☐	☐
5. Are your teeth crowding or developing spaces?	☐	☐
6. Do you have more than one bite and squeeze to make your teeth fit together?	☐	☐
7. Do you chew ice, bite your nails, use your teeth to hold objects or have any other oral habits?	☐	☐
8. Do you clench your teeth in the daytime or do they become sore?	☐	☐
9. Do you have any problems with sleep or wake up with an awareness of your teeth?	☐	☐
10. Do you wear or have you ever worn a bite appliance?	☐	☐

Tooth Structure

1. Have you had any cavities within the past 3 years?	☐	☐
2. Does the amount of saliva in your mouth seem too little or do you have any difficulty swallowing any food?	☐	☐
3. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?	☐	☐
4. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?	☐	☐
5. Do you have any grooves or notches on your teeth near the gum line?	☐	☐
6. Have you ever had broken teeth, chipped teeth, or had a toothache, or cracked filling?	☐	☐
7. Do you frequently get food caught between any teeth?	☐	☐

Biology

1. Do your gums bleed or are they painful when brushing or flossing?	☐	☐
2. Have you ever been treated for gum disease or been told you have lost bone around your teeth?	☐	☐
3. Have you ever noticed an unpleasant odor in your mouth?	☐	☐
4. Is there anyone with a history of periodontal disease in your family?	☐	☐
5. Have you ever noticed gum recession?	☐	☐
6. Have you ever had any teeth become loose on their own (no injury), or do you have difficulty eating an apple?	☐	☐
7. Have you experienced a burning sensation in your mouth?	☐	☐

FINANCIAL POLICY

This agreement is to inform you of your financial obligation to our practice. This financial agreement is intended to facilitate our ability to provide excellent service to you while minimizing our administrative costs.

Insurance

As a courtesy to you, we will help you process all your insurance claims. In order for our practice to file your insurance claim, you must provide proof of insurance either with a card or information provided to the office when setting up the appointment. ***All charges you incur are your responsibility regardless of your insurance coverage.***

Payment Due at Time of Service

Our policy is: **"Payment Due at Time of Service"**. Your **estimated** co-payment for treatment, which is the amount not covered by insurance, is due at the time treatment is provided. Your **estimated** co-payment may be adjusted after the time of treatment depending on the final reconciliation of insurance payments. If you do not have insurance, we expect **full payment** for service at each office visit.

We accept these forms of payment:

Cash - Check - Master Card - Visa - Discover - American Express - Care Credit

Payment Plans

Our office is able to offer a three month payment plan option. You are eligible for a payment plan if you are a ***patient on record***, have shown ***good credit***, and if you total balance exceeds ***$500***. Our policy for a payment plan is to only accept ***post-dated checks*** or a ***valid credit card number*** to draw from on a specified day of each month. The checks or card information must be given at the time of service. If your treatment exceeds the cost of $1000, fifty percent will be the expected payment at the time of service. The remaining balance can then be processed on a payment plan.

Interest

Returned checks and balances older than 90 days will be subject to collection fees and charges at the rate of 1.5% per month (18% annually).

Please don't hesitate to ask if you have any questions regarding this financial agreement. We are committed to providing you with the ultimate experience in dental care, but need your financial committment as well.

Print name of patient or responsible party _____ Date: _____

Signature of patient or responsible party _____ Date: _____

Appointment Policy

I understand the cancellation policy which states "Reserved times cancelled within 48 hours are subject to a $50.00 cancellation fee". An appointment cancelled within 48 hours limits our ability to fill the time with a patient in need. We appreciated your understanding and working with us to avoid this scenario.

Signature of patient or responsible party _____ Date: _____