moderndentistry

REGISTRATION

PATIENT INFORMATION

first name | last name | nickname

gender | marital status | birthdate | ss#

address

city | state | zip

email

home phone | work phone | cell phone

whom may we thank for referring you to our office?

notify in case of emergency | phone

EMPLOYMENT

patient's employer | occupation

employer address

city | state | zip

INSURANCE

insured person's name

relationship to patient | birthdate | id#

address (if different from patient's)

city | state | zip

insured person's employer

insurance company | group #

insurance company address | phone

city | state | zip

AUTHORIZATION

I authorize and give consent to the performance of dental services for myself (or my dependent). I give consent to any necessary or advisable dental procedures, medications, or anesthetics to be administered by the attending dentist or by the supervised staff for diagnostic purposes or dental treatment. I understand that using anesthetic agents embodies certain risks.

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits.

I understand that I am financially responsible for payment of services rendered, regardless of insurance coverage.

patient signature | date

OUR POLICIES

Payment is due at the time services are rendered unless other arrangements have been made. Returned checks and outstanding balances over 60 days are subject to collections fees and an interest rate of 1.5% per month. If required, I also understand a check of my credit history may be made.

There is a charge for broken appointments and those cancelled within 24 hours notice. If I miss an appointment without notifying your office, I will be required to pay a 50% deposit (non-refundable) towards my next appointment before scheduling.

I may receive a treatment plan which estimates my portion of payment. If the staff estimates and collects my co-payment and my insurance underpays or denies a benefit, I am responsible for the remaining balance. Not all services are covered in all insurance contracts. Insurance companies arbitrarily select certain procedures they do not cover, based upon the premium/contract arranged by my employer.

patient signature | date

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HEALTH HISTORY

DENTAL HISTORY

reason for today's visit

former dentist | city | phone

date of last dental visit | date of last xrays

how often do you brush? | how often do you floss?

check (✓) if you have or have had problems with any of the following:

- ☐ bleeding gums
- ☐ clicking or popping jaw
- ☐ cold sores or other oral lesions
- ☐ food collection between teeth
- ☐ grinding teeth
- ☐ loose teeth or broken fillings
- ☐ mouth odors or bad tastes
- ☐ oral surgery
- ☐ orthodontic treatment
- ☐ periodontal treatment
- ☐ sensitivity to hot or cold
- ☐ sensitivity to sweets
- ☐ sensitivity when biting

are you satisfied with the appearance of your teeth?

would you like a whiter smile?

would you like straighter teeth?

MEDICAL HISTORY

are you currently under physician care? | if so, please explain

physician's name | phone

have you had any serious illnesses or operations? | if so, please explain

women: are you pregnant? | if so, how many months? | nursing? | taking birth control pills?

check (✓) if you have or have had any of the following:

- ☐ anemia
- ☐ arthritis/rheumatism
- ☐ artificial heart valves
- ☐ artificial joints
- ☐ asthma
- ☐ back problems
- ☐ blood disease
- ☐ blood transfusion
- ☐ cancer/tumors
- ☐ chemical dependency
- ☐ chemotherapy
- ☐ circulatory problems
- ☐ cortisone treatments
- ☐ cough, persistent
- ☐ cough up blood
- ☐ diabetes
- ☐ epilepsy/seizures
- ☐ fainting/dizziness
- ☐ glaucoma
- ☐ headaches
- ☐ heart murmur
- ☐ heart problems
- ☐ hemophilia/abnormal bleeding
- ☐ herpes
- ☐ hepatitis
- ☐ high blood pressure
- ☐ HIV+/AIDS
- ☐ jaw pain
- ☐ kidney disease
- ☐ liver disease
- ☐ mitral valve prolapse
- ☐ pacemaker/heart surgery
- ☐ psychiatric care
- ☐ radiation treatment
- ☐ rapid weight gain or loss
- ☐ respiratory disease
- ☐ rheumatic/scarlet fever
- ☐ shortness of breath
- ☐ sinus problems
- ☐ skin rash
- ☐ stroke
- ☐ swelling of feet or ankles
- ☐ thyroid disease
- ☐ tobacco habit
- ☐ tonsillitis
- ☐ tuberculosis
- ☐ ulcer
- ☐ venereal disease

do you have or have you had any disease, condition or problem not listed above? | if so, please explain

list medications you are currently taking:

list allergies to any medication or substance:

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered every question on this form completely and accurately, to the best of my knowledge. I will inform my dentist of any change in my health and/or medication.

patient signature | date

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ , have received a copy of this office's Notice of Privacy Practices.

patient signature _____ date _____

ACKNOWLEDGMENT OF RECEIPT OF DENTAL MATERIALS FACT SHEET

I, _____ , have received from this office a copy of the Dental Materials Fact Sheet dated October 2001.

patient signature _____ date _____