Family DENTAL Care

PATIENT REGISTRATION

Patient Information:

First Name: _____Last Name: _____ M.I.: _____ Preferred Name: _____

Birth Date: _____ Soc. Sec: _____ Maiden Name: _____

O Male O Female O Married O Single O Divorced O Separated O Widowed

Address: _____ City, State, and Zip: _____

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

Employment Status: O Full Time O Part Time O Retired

Name of Employer/Occupation: _____

Student Status: O Full Time O Part Time Name of School: _____

Spouse Name: _____ Birth Date: _____ Soc. Sec: _____

Please indicate preference of appointment confirmation:

○ Automated phone call
○ Text message
○ E-mail address _____

Responsible Party (if someone other than the patient):

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

Birth Date: _____ Soc. Sec: _____

Address: _____

City, State, and Zip: _____

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

Name of Employer: _____

Primary Insurance Information: **Office Use:** O Insurance Card Copied

Name of Policy Holder: _____

Relationship to Insured: O Self O Spouse O Child O Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Insurance Company: _____

Secondary Insurance Information: **Office Use:** O Insurance Card Copied

Name of Policy Holder: _____

Relationship to Insured: O Self O Spouse O Child O Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Insurance Company: _____

*** CONTINUED ON BACK SIDE ***

MEDICAL HEALTH HISTORY

Do you have a current Medical Doctor? ☐ Yes ☐ No If yes _____

Do you have an emergency contact? (Someone not living with you) ☐ Yes ☐ No If yes _____phone:_____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes _____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes _____

Have you ever had any complications following dental treatment? ☐ Yes ☐ No If yes _____

Have you ever been told you require a pre-med prior to dental treatment? ☐ Yes ☐ No If yes _____

Have you ever taken Fosamax, Boniva, Actonel or any medication containing bisphosphonates? ☐ Yes ☐ No If yes _____

Are you taking any CURRENT MEDICATIONS? If none, please write NONE ☐ Yes ☐ No If yes _____

_____

Are you ALLERGIC to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Any other allergies not listed above? ☐ Yes ☐ No If yes _____

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

☐ Alzheimer's Disease	☐ Dementia	☐ High Blood Pressure	☐ Rheumatic Fever
☐ Anaphylaxis	☐ Diabetes	☐ HIV Positive/AIDS	☐ Rheumatism
☐ Anemia	☐ Easily Winded	☐ Irregular Heartbeat	☐ Scarlet Fever
☐ Arthritis/Gout	☐ Emphysema	☐ Kidney Problems	☐ Sinus Trouble
☐ Artificial Heart Valve	☐ Epilepsy or Seizures	☐ Leukemia	☐ Shingles
☐ Artificial Joint	☐ Excessive Bleeding	☐ Liver Disease	☐ Soda/Gatorade Use
☐ Asthma	☐ Fainting Spells/Dizziness	☐ Low Blood Pressure	☐ Stomach/Intestinal Disease
☐ Blood Disease	☐ Frequent Headaches	☐ Lung Disease	☐ Stroke
☐ Blood Transfusion	☐ Glaucoma	☐ Mitral Valve Prolapse	☐ Swelling in Limbs
☐ Breathing Problems	☐ Heart Attack/Failure	☐ Osteoporosis	☐ Thyroid Disease
☐ Bruise Easily	☐ Heart Murmur	☐ Pain in Jaw Joints	☐ Tobacco Use
☐ Cancer	☐ Heart Pacemaker	☐ Phen-Phen/Redux	☐ Tuberculosis
☐ Chemotherapy	☐ Heart Trouble/Disease	☐ Pregnant (Currently)	☐ Tumors/Growths
☐ Chest Pains	☐ Hepatitis A	☐ Psychiatric Care	☐ Ulcers
☐ Cold Sores/Fever Blisters	☐ Hepatitis B or C	☐ Radiation Treatment	☐ Yellow Jaundice
☐ Congenital Heart Disorder	☐ Herpes	☐ Recent Weight Loss	

Do you have any health problems that need further clarification? ☐ Yes ☐ No

If yes _____

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 health. It is my responsibility to inform Family Dental Care of any changes in medical status.

_____ _____

Signature of Patient, Parent or Guardian Date

Informed Consent for Services and Financial Policy

Emergency service is usually limited to relief of pain only and does not commit the performing dentist to provide further treatment. **All first visits will include a comprehensive exam and x-rays.** If accepted for treatment I give permission to Family Dental Care to perform these procedures considered necessary for my emergency of initial dental care.

Patients who carry dental insurance must present all information at time of check in. All incurred charges are ultimately the responsibility of the patient regardless of insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, and not with your insurance company. Your insurance plan is a contract between you, your employer, and your insurance company. Our office is not a party to that contract or any possible restrictions. Financial arrangements **must** be made in advance to any appointments. As a courtesy to our patients, our office will help prepare insurance forms or assist in making collections from the insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. Patient also authorizes payment of all dental benefits payable directly to Family Dental Care. Also authorizes release of any information relating to dental claims, to the extent permitted under applicable laws.

A **finance charge** of 1.5% per month (18% annum) on the unpaid balance will be charged on all accounts exceeding 60 days. A rebilling fee of $25 may also be added to the account. There is a $40 fee for checks returned by the bank.

I understand that the fee estimate listed for any dental care can only be extended for a period of 3 months from the date of the patient examination. An estimate of treatment will be sent to insurance. That estimate **does not** guarantee payment from the insurance company.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of anytime or condition hereunder shall constitute a waiver of any further term of condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I understand that this office reserves the right not to appoint any persons due to bad credit standings and/or three failed appointments.

I grant my permission to you or your assignee, to telephone me at home or at work to discuss matters related to this form.

Signature: _____ Date: _____