

Registration

Name _____ Date of Birth _____

Address _____ Home Phone _____

City _____ State _____ Zip _____ Soc. Sec. No. _____

Name of person responsible for this account _____

Address _____ City _____ State _____ Zip _____

Patient's Employer _____ Position _____ Bus. Phone _____

Spouse's Full Name _____

Spouse's Employer _____ Position _____ Bus. Phone _____

If Full-time Student, please list where _____

If for child or teen, please list:

• Parent's Full Name _____ Employer _____ Bus. Phone _____

• Parent's Full Name _____ Employer _____ Bus. Phone _____

Nearest relative not living with you _____ Phone _____

In case of emergency, please call _____ Phone _____

Who may we thank for this referral? _____

Do you have Dental Insurance? Yes _____ No _____ (if yes please continue)

Do you have Medical Assistance? Yes _____ No _____ (if yes, please present card)

I hereby authorize the administration of such medications and performance of such diagnostic and therapeutic procedures as may be necessary for proper dental care.

signature (parent or guardian, if minor)

date

Patient Insurance Information

Policy Holder _____

Birth Date _____ Soc. Sec. No. _____

Address _____ City _____ State _____ Zip _____

Policy Holder's Employer _____

Address _____ City _____ State _____ Zip _____

Insurance Company _____

Address _____ City _____ State _____ Zip _____

Group Contract # _____

Employee # _____

Your dental insurance is a contract between you, your employer, and the insurance company. We are not a party in that contract. Our fees are generally considered to fall within the acceptable range by most companies and therefore are covered up to the maximum allowance determined by each carrier. This applies to only to companies who pay a percentage (such as 50% or 80%) of "U.C.R." U.C.R. is defined as usual, customary, and reasonable fees for this region. Thus, our fees are considered usual, customary, and reasonable by most companies. This statement does not apply to companies who reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.

Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that as dental care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy we extend to our patients, all charges are the patient's responsibility from the date the services are rendered. We realize that temporary financial difficulties may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, Please don't hesitate to ask us. We are here to help.

The undersigned, hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my dentist to submit claims for benefits, for services rendered or to be rendered without obtaining my signature on each and every claim to be submitted for myself and/or my dependents and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

Authorized signature of Covered Person/Employee

Medical and Dental History

Circle any of the following conditions you have had:

Heart trouble	asthma	excessive bleeding	congenital heart lesions
Stroke	heart murmur	diabetes	epilepsy
Tuberculosis	anemia	psychiatric treatment	high blood pressure
Hepatitis	sinus trouble	rheumatic fever	jaundice
HIV/AIDs	eating disorder	chemical dependency	other _____

(Women) Are you currently pregnant? _____ Due date _____

Do you have allergies to any medications? Please list: _____

Please list all medications and dosages of drugs you are presently taking: _____

Have you had any other serious illness, hospitalization, or accident? Yes _____ No _____

If yes, please explain _____

- Name and address of physician _____
- When was your last physical exam? _____
- Are you currently under the care of a physician? Yes _____ No _____
If yes, for what reason? _____

Former Dentist _____ Address _____

When did you last visit a dentist? _____ X-rays taken? Yes _____ No _____

What was done at that time? _____

Did you make regular visits to the dentist before that time? Yes _____ No _____

Are you aware of a dental problem in your mouth? Yes _____ No _____

Explain _____

What do you feel is the condition of your mouth? _____

- Do your gums bleed? Yes _____ No _____
- Have you ever been told that you have gum disease? Yes _____ No _____
- Does food collect between your teeth? Yes _____ No _____
- Are your teeth sensitive to: Sweet _____ Cold _____ Heat _____ Pressure _____
- How often do you brush your teeth? _____
- How often do you floss your teeth? _____
- Are you interested in preventing further dental problems by having regular dental exams and care? Yes _____ No _____

Is there anything else about your dental history that would be valuable for me to know? _____

Patient (or Parent/Guardian if minor) _____ Date _____

Staff Signature _____ Date _____