Patient Registration Form

American Dental Association
www.ada.org

Email: Today's Date:

Preferred Name: ❑ Miss ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. Referred by:

Name: Last First Middle Home Phone: *include area code* ( ) Cell Phone: *include area code* ( )

Address: Mailing address City: State: Zip:

SS#: Date of Birth: Sex: M F

Employer: Business Phone: *include area code* ( )

Emergency Contact: Relationship: Home Phone: *include area code* ( ) Cell Phone: *include area code* ( )

College Student Status: ❑ Full Time ❑ Part Time Please provide school info: School Name:

Employment Status: ❑ Full Time ❑ Part Time ❑ Retired Address:

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed Address 2:

Pref. Pharmacy: Phone: ( ) City, State, Zip:

Dental Insurance Information

Primary Insurance Information

Name of Insured: Relationship to Patient: ❑ Self ❑ Spouse ❑ Child ❑ Other

Insured Soc. Sec.: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

ID#: Gr#:

Secondary Insurance Information

Name of Insured: Relationship to Patient: ❑ Self ❑ Spouse ❑ Child ❑ Other

Insured Soc. Sec.: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

ID#: Gr#:

Dental Information

For the following questions, mark (X) your responses to the following questions.

	Yes	No	DK
Do your gums bleed when you brush or floss?	❑	❑	❑
Are your teeth sensitive to cold, hot, sweets or pressure?	❑	❑	❑
Is your mouth dry?	❑	❑	❑
Have you had any periodontal (gum) treatments?	❑	❑	❑
Have you ever had orthodontic (braces) treatments?	❑	❑	❑
Have you had any problems associated with previous dental treatment?	❑	❑	❑
Is your home water supply fluoridated?	❑	❑	❑
Do you drink bottled or filtered water?	❑	❑	❑
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY			
Are you currently experiencing dental pain or discomfort?	❑	❑	❑

	Yes	No	DK
Do you have earaches or neck pains?	❑	❑	❑
Do you have any clicking, popping or discomfort in the jaw?	❑	❑	❑
Do you brux or grind your teeth?	❑	❑	❑
Do you have sores or ulcers in your mouth?	❑	❑	❑
Do you wear dentures or partials?	❑	❑	❑
Do you participate in active recreational activities?	❑	❑	❑
Have you ever had a serious injury to your head or mouth?	❑	❑	❑

Date of your last dental exam:
What was done at that time?

Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

over

Medical Information

Please mark (X) your responses to indicate if you have or have not had any of the following diseases or problems.

(Check DK if you Don't Know the answer to the question) Yes No DK

Are you now under the care of a physician? . . . . . ❑ ❑ ❑

Physician Name: _____

Phone: *include area code* (_____) _____

Address/City/State/Zip: _____

_____

Are you in good health? . . . . . ❑ ❑ ❑

Has there been any change in your general health within the past year? . . . . . ❑ ❑ ❑

If yes, what condition was treated? _____

_____

Date of last physical exam: _____

Do you wear contact lenses? . . . . . ❑ ❑ ❑

Are you taking, or have you taken, any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine) or fen-phen (fenfluramine-phentermine combination)? . . . . . ❑ ❑ ❑

Are you taking or scheduled to begin taking either of the medications alendrontate (Fosamax®) or risendronate (Actonel®) for osteoporosis or Paget's disease? . . . . . ❑ ❑ ❑

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastic cancer? . . . . . ❑ ❑ ❑

Date Treatment Began: _____

Yes No DK

Have you had a serious illness, operation or been hospitalized in the past 5 years? . . . . . ❑ ❑ ❑

If yes, what was the illness or problem? _____

Are you taking or have you recently taken any prescription or over the counter medicine(s)? . . . . . ❑ ❑ ❑

If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements: _____

_____

_____

_____

Do you use controlled substances (drugs)? . . . . . ❑ ❑ ❑

Do you use tobacco (smoking, snuff, chew, bidis)? . . . . . ❑ ❑ ❑

If so, how interested are you in stopping?
Circle one: VERY / SOMEWHAT / NOT INTERESTED

Do you drink alcoholic beverages? . . . . . ❑ ❑ ❑

If yes, how much alcohol did you drink in the last 24 hours? _____

If yes, how much do you typically drink in a week? _____

WOMEN ONLY Are you:

Pregnant? . . . . . ❑ ❑ ❑

Number of weeks: _____

Taking birth control pills or hormone replacement? . . . . . ❑ ❑ ❑

Nursing? . . . . . ❑ ❑ ❑

Joint Replacement. Have you had an orthopedic total joint replacement (hip, knee, elbow, finger)? . . . . . ❑ ❑ ❑

Date: _____ If yes, have you had any complications?

Allergies - Are you allergic to, or have you had a reaction to: **Yes No DK**

To all **yes** responses, specify type of reaction.

Local anesthetics _____ ❑ ❑ ❑

Aspirin _____ ❑ ❑ ❑

Penicillin or other antibiotics _____ ❑ ❑ ❑

Barbituates, sedatives, or sleeping pills _____ ❑ ❑ ❑

Sulfa drugs _____ ❑ ❑ ❑

Codeine or other narcotics _____ ❑ ❑ ❑

Metals _____ ❑ ❑ ❑

Latex (rubber) _____ ❑ ❑ ❑

Iodine _____ ❑ ❑ ❑

Hay fever / seasonal _____ ❑ ❑ ❑

Animals _____ ❑ ❑ ❑

Food _____ ❑ ❑ ❑

Other _____ ❑ ❑ ❑

	Yes	No	DK
Heart murmur	❑	❑	❑
Mitral valve prolapse	❑	❑	❑
Artificial heart valves	❑	❑	❑
Rheumatic fever	❑	❑	❑
Cardiovascular disease	❑	❑	❑
Angina	❑	❑	❑
Arteriosclerosis	❑	❑	❑
Congestive heart failure	❑	❑	❑
Coronary artery disease	❑	❑	❑
Damaged heart valves	❑	❑	❑
Heart attack	❑	❑	❑
Low blood pressure	❑	❑	❑
High blood pressure	❑	❑	❑
Congenital heart defects	❑	❑	❑
Pacemaker	❑	❑	❑
Rheumatic heart disease	❑	❑	❑
Abnormal bleeding	❑	❑	❑

	Yes	No	DK
Anemia	❑	❑	❑
Blood transfusion	❑	❑	❑
If yes, date: _____			
Hemophilia	❑	❑	❑
AIDS or HIV infection	❑	❑	❑
Arthritis	❑	❑	❑
Autoimmune disease	❑	❑	❑
Rheumatoid arthritis	❑	❑	❑
Systemic lupus erythematosus	❑	❑	❑
Asthma	❑	❑	❑
Bronchitis	❑	❑	❑
Emphysema	❑	❑	❑
Sinus trouble	❑	❑	❑
Tuberculosis	❑	❑	❑
Cancer/Chemotherapy/ Radiation treatment	❑	❑	❑

	Yes	No	DK
Chest pain upon exertion	❑	❑	❑
Chronic pain	❑	❑	❑
Diabetes Type I or II	❑	❑	❑
Eating disorder	❑	❑	❑
Malnutrition	❑	❑	❑
Gastrointestinal disease	❑	❑	❑
G.E. Reflux/Persistent heartburn	❑	❑	❑
Ulcers	❑	❑	❑
Thyroid problems	❑	❑	❑
Stroke	❑	❑	❑
Glaucoma	❑	❑	❑
Hepatitis, jaundice or liver disease	❑	❑	❑
Epilepsy	❑	❑	❑
Fainting spells or seizures	❑	❑	❑

	Yes	No	DK
Neurological disorders	❑	❑	❑
If yes, specify: _____			
Sleep disorder	❑	❑	❑
Mental health disorders	❑	❑	❑
If yes, specify: _____			
Recurrent infections	❑	❑	❑
Type of infection: _____			
Kidney problems	❑	❑	❑
Night sweats	❑	❑	❑
Osteoporosis	❑	❑	❑
Persistent swollen glands in neck	❑	❑	❑
Severe headaches/ Migraines	❑	❑	❑
Severe of rapid weight loss	❑	❑	❑
Sexually transmitted disease	❑	❑	❑
Excessive urination	❑	❑	❑

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? . . . . . ❑ ❑ ❑

Name of physician or dentist making recommendation: _____ Phone: (_____) _____

Do you have any disease, condition, or problem not listed above that you think I should know about? . . . . . ❑ ❑ ❑

Please explain: _____

NOTE: Both Doctor and patient are encouraged to discuss any and all relevent patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will reyl on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: _____ Date: _____

GENERAL CONSENT FOR TREATMENT

I, the undersigned, hereby authorize my doctor(s) to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of my determined needs. I understand that x-rays are required on a yearly basis for accurate diagnosis. I understand that the use of anesthetic agents embodies a certain risk and I acknowledge that I have provided a thorough and honest report of my medical and dental history.

I understand that any treatment plans presented along with fee outlines, could change depending on the time elapsed since the initial examination and extent of dental treatment. Occasionally once the treatment plan has been started, complications may arise that dictate additional procedures or treatment. The doctors or their staff will always advise me of any changes. I understand that there is no guarantee to the outcome of any services performed.

PERIODONTAL MAINTENANCE

Periodontal maintenance is always scheduled following scaling and root planning. Please be aware there may be a patient co-payment for this service.

RESIN (TOOTH COLORED) FILLINGS

As a premier esthetic practice, we always recommend resin fillings to our patients**.** We strongly believe this to be a superior esthetic restoration. According to the terms of your insurance plan, if you chose to have resin fillings you will need to pay the difference between the amalgam (silver) and resin restoration.

Signature: _____

Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

Signature: _____

Date: _____

AGREEMENT TO RECEIVE ELECTRONIC COMMUNICATION

I am aware that there is some level of risk that third parties might be able to read unencrypted emails. I further agree that I am responsible for providing the dental practice any updates to my email address and/or phone number. I would like the office to contact me regarding:
(INITIAL BELOW)
___ text correspondence
___ email correspondence
___ Appointment Reminders/Recall Visits
___ Information regarding insurance/billing
___ Requests for Patient Satisfaction online reviews
I can withdraw my consent to electronic communication at any time by contacting:
Heritage Dental , 609-625-0300, azdradental@gmail.com

FINANCIAL POLICIES FORM

Thank you for choosing our Practice! In an effort to better serve you, we would like to take the time to explain the billing process at our office.

Payment is expected the day services are rendered. For patients with dental insurance, if you provide the office with your dental insurance information, we will contact your insurance company and verify your benefits. We will do our very best to answer any questions you may have about your insurance coverage but always suggest that you contact them directly whenever possible.

As a courtesy to you, we will gladly submit the insurance claim to your insurance company on the day of service. We will collect the estimated co-payment and deductible at each visit. We make every effort to determine your insurance benefits when you receive treatment but consider your co-payment an **estimate** until we receive payment from your insurance company. Please remember that any information we provide relative to your insurance coverage is our best **estimate** and not a guarantee of the payment that will be received.

In order to provide quality dental care in a timely manner, we have a cancellation and no-show policy. The policy enables us to better utilize available appointments for our patients in need of dental care

CANCELLATION OF AN APPOINTMENT

In order to be respectful of other patient's needs, please be courteous and call our office promptly if you are unable to keep your appointment. This time will be given to someone who is in urgent need of treatment. We ask that you notify us 48 business hours in advance, in order to cancel or reschedule any appointments.

NO SHOW POLICY

A "no show" is an appointment that was not cancelled in advance (48 business hours). No shows inconvenience other patients who need dental care. A no show for a scheduled appointment will be charged $50.00 if scheduled with a hygienist, or $100.00 if scheduled with the dentist.

LATE ARRIVALS

If you are running late for your appointment, please call the office. If you are more than 15 minutes late to your scheduled appointment, you may be asked to reschedule.

I have read and understand the appointment policies at Heritage Dental. I have also read and understand the billing procedures at Heritage Dental. I agree to be responsible for full payment of all charges for dental services performed on me. If for any reason the insurance does not pay its estimated portion, I agree that I will be responsible for the account balance. In the event that my account is placed with third party collection agency or attorney, I will be assessed any fees relating to this action.

Print Name: _____

Signature: _____

Date: _____