PATIENT REGISTRATION

ID: ________ Chart ID: ________

First Name: ________ Last Name: ________ Middle Initial: ____

Patient Is: ☐ Policy Holder ☐ Responsible Party

Preferred Name: ________

Responsible Party (if someone other than the patient)

First Name: ________ Last Name: ________ Middle Initial: ____

Address: ________ Address 2: ________

City, State, Zip: ________ Pager: ________

Home Phone: ________ Work Phone: ________ Ext: ________ Cellular: ________

Birth Date: ________ Soc Sec: ________ Drivers Lic: ________

○ Responsible Party is also a Policy Holder for Patient ○ Primary Insurance Policy Holder ○ Secondary Insurance Policy Holder

Patient Information

Address: ________ Address 2: ________

City: ________ State / Zip: ________ ________ Pager: ________

Home Phone: ________ Work Phone: ________ Ext: ________ Cellular: ________

Sex: ○ Male ○ Female Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth Date: ________ Age: ________ Soc. Sec: ________ Drivers Lic: ________

E-mail: ________ ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ○ Full Time ○ Part Time ○ Retired

Student Status: ○ Full Time ○ Part Time

Medicaid ID: ________ Pref. Dentist: ________

Employer ID: ________ Pref. Pharmacy: ________

Carrier ID: ________ Pref. Hyg.: ________

Section 3

EMER CONTACT: ________

EMER PHONE : ________

Your Occupation: ________

Your Employer: ________

Previous dentist : ________

Previous dentist #: ________

Last dental visit: ________

Primary Insurance Information

Name of Insured: ________ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: ________ Insured Birth Date: ________

Employer: ________

Address: ________

Address 2: ________

City,State,Zip: ________

Ins. Company: ________

Address: ________

Address 2: ________

City,State,Zip: ________

Rem. Benefits: .00 Rem. Deduct: .00

Secondary Insurance Information

Name of Insured: ________ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: ________ Insured Birth Date: ________

Employer: ________

Address: ________

Address 2: ________

City,State,Zip: ________

Ins. Company: ________

Address: ________

Address 2: ________

City,State,Zip: ________

Rem. Benefits: .00 Rem. Deduct: .00

MEDICAL HISTORY

PATIENT NAME ______________________________ Birth Date ______________________

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.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: ______________
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: ______________
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: ______________
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: ______________
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No ______________
Are you on a special diet? ◯ Yes ◯ No ______________
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics
☐ Other If yes, please explain: ______________

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

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

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: ______________

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 patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN ______________________ DATE ______________

Patient Name____________________ Date_____________

DENTAL HISTORY

Previous dentist______________ How long were you a patient?_______ Reason for leaving __________________
Date of most recent treatment (other than cleaning) __/__/__
I routinely see my dentist every: □3 mo □ 4 mo □6 mo □12 mo □ not routinely
How would you rate the condition of your mouth? □ Excellent □Good □ Fair □ Poor
Are you fearful of dental treatment? _____ Scale of 1 to 10? ______
Have you had an unfavorable dental experience? ________
Have you ever had complications from past dental treatment?
Have you ever had difficulty getting numb or reactions to local anesthetics?
Have you had injury or trauma to your head, neck, or jaw joint?

WHAT PROMPTED YOU TO SEEK DENTAL CARE AT THIS TIME? __________________________
____

	YES	NO
GUM AND BONE		
1. Have you ever been diagnosed with or treated for periodontal disease?	( )	( )
2. Have you ever experienced gum recession?	( )	( )
3. Is there anyone with a history of periodontal disease in your family?	( )	( )
4. Do your gums bleed with brushing, flossing or eating?	( )	( )
5. Are your teeth becoming loose?	( )	( )
6. Have you ever noticed an unpleasant odor in your mouth?	( )	( )
7. Have you experienced a burning sensation in your mouth?	( )	( )
BITE AND JAW JOINT		
8. Do you/ would you have problems chewing gum?	( )	( )
9. Do you/ would you have problems chewing bagels or other hard foods?	( )	( )
10. Have your teeth changed in the last 5 years?	( )	( )
11. Are your teeth crowding or developing spaces?	( )	( )
12. Do you have more than one bite or do you clench your teeth to get them to fit together?	( )	( )
13. Do you have any problems with sleep or wake up with awareness of your teeth?	( )	( )
14. Do you have problems with your jaw joint? (pain, sounds, limited opening, popping)	( )	( )
15. Do you have tension headaches or sore teeth?	( )	( )
16. Do you wear or have ever worn a bite appliance?	( )	( )
17. Have you ever had braces, orthodontic treatment, or your bite adjusted?	( )	( )
18. Have you ever been treated for TMD?	( )	( )
TOOTH STRUCTURE		
19. Have you had any cavities in the last 3 years?	( )	( )
20. Do you have a dry mouth?	( )	( )
21. Are any teeth sensitive to hot, cold, biting, or sweets?	( )	( )
22. Have you ever had a toothache, cracked filling, broken, chipped, or cracked tooth?	( )	( )
23. Do you avoid brushing any part of your mouth?	( )	( )
24. Do you feel or notice any holes or pits in your teeth?	( )	( )
25. Do you have areas where food gets caught between your teeth?	( )	( )
SMILE CHARACTERISTICS		
26. Is there anything about the appearance of your teeth that you would like to change?	( )	( )
27. Have you ever whitened (bleached) your teeth?	( )	( )
28. Are you self conscious about your teeth?	( )	( )
28. Have you ever been disappointed with the appearance of previous dental work?	( )	( )

Patient's Signature ____ **Date** ___________________

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Dr. Billings keeps a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge that I have been informed of the Notice of Privacy Practices.

____ ____________

Patient or legally authorized individual signature Date

____ ____________

Printed Name if signed on behalf of the patient Relationship

FINANCIAL POLICY

Thank you for choosing Dr Billings and her professional dental team to provide your dental care. We will provide you with treatment recommendations, fees and estimated dental insurance coverage. We are here to assist you with treatment decisions, and to provide you with several cost effective options.

PAYMENT POLICY:

Payment is due at the time of treatment unless other arrangements have been made in advance. For your convenience we offer several payment options, including cash, check and credit cards (Visa, MasterCard, or Discover logo).

FOR OUR PATIENTS WITH DENTAL INSURANCE:

For those patients who have the good fortune to have dental insurance, we provide an “estimate” of what your insurance will pay. As a courtesy to our patients, we will bill your insurance company for completed procedures, and accept assignment of dental insurance benefits for those procedures. However, we require the “uninsured” portion (including deductibles, and co-payments, and uncovered costs) at the time of service. Occasionally there is a balance due, and if it extends beyond 90 days there is a finance charge of 1% monthly.

Your dental insurance policy is a contract between you and your insurance company. It is your responsibility to know and understand your policy and to keep track of your dental coverage. Sometimes it will involve a phone call to your insurance company to verify your coverage and benefits. Be sure you are aware of your frequency limitations, deductibles, and plan maximums. We will try to assist you in getting this information, and help verify your level of coverage prior to providing services to prevent any misunderstanding in this regard.

FOR OUR UNINSURED PATIENTS:

We appreciate your commitment to excellent dental care even without the help of dental insurance. Payment for services is due at the time of treatment. If you pay by cash or check before or at the time of service a 5% payment discount is offered.

PAYMENT PLAN OPTION:

We are able to offer a monthly payment plan to help you pay for treatment through a third party company called Care Credit. Although our office is charged a fee for your account with Care Credit we happily do this to help make dental care more affordable for you. You will need to apply to this agency, to qualify for the loan and set up your program prior to starting your dental care. Dental treatment is charged to your “Care Credit card” at the time of treatment.

CANCELLATION POLICY:

Our office requires a minimum of 48-office hours (Monday through Wednesday, we are closed Thursday and Friday) notice if an appointment must be rescheduled or cancelled. Failure to provide at least 48-office hours’ notice before canceling or rescheduling an appointment may result in an assessment of a $75 fee to your account.

I HAVE READ THE ABOVE POLICIES AND UNDERSTAND MY FINANCIAL RESPONSIBILITIES AS A PATIENT.

SIGNED____ DATE___________________