Patient Registration

Name_____,_____,_____
(Last) (First) (MI)

Address_____,_____,_____,_____
(Number, Street P.O. Box) (City) (State) (Zip Code)

Home Phone: _____ Mobile Number:_____

Business Phone: _____

E-mail:_____ Prefer text/email/both?_____

Date of Birth_____ Sex____ Height_____ Weight_____ Social Security #_____
Occupation_____Employer_____

Single ___ Married ___ Name of Spouse _____

Closest Relative _____Relationship_____Phone _____

Referred by _____

MEDICAL HISTORY

1.What is your general health?
Good Fair Poor { Y } { N }
2. Are you being treated by a physician now? { } { }
3. Has there been any change in your general health in the past year? { } { }
4. Have you ever been hospitalized? { } { }
5. Have you ever had surgery? { } { }
6. Have you had a blood transfusion? { } { }
7. Have you had an injury to your face or jaw? { } { }
8. Have you ever been treated for a growth or tumor in your body? { } { }
9. Are you ever short of breath on mild exertion? { } { }
10. Do your ankles ever swell? { } { }
11. Is it likely that you are pregnant? { } { }
12. Are you taking any drugs or medications? If so, what?
Explain { } { }

_____
_____

13.Are you a smoker? Yes□ No □
If so, approximately how many per day?_____
14. Do you take Aspirin on a daily basis or blood thinner?_____
15. Have you had any of the following? (Please circle)

Heart disease	Artificial joint
Liver disease	Lung disease
Chest Pain	Seizures
Hepatitis type A B C	Anemia
Asthma	Stroke
Arthritis	Diabetes type I II
Bleeding problem	Ulcer
High blood pressure	Thyroid problems
Heart murmur	Kidney Problem
Tuberculosis	Jaundice
Venereal disease	Hearing problems
HIV positive	AIDS
Rheumatic fever	Implant
Scarlet fever	Psychiatric problems

Cancer, what type?_____
16. Are you allergic to any medication?_____
_____
17. Do you require PreMed?_____

DENTAL HISTORY

1.What is the purpose of your visit?_____

2. How often do you brush your teeth?_____ Floss?_____

3. Have you ever had difficult extractions? _____ 4. Have you had any unpleasant dental experiences?_____

5. What concerns you most about your mouth or oral health?_____

6. Are you difficult to anesthetize(numb)?_____

7. When was your last dental visit?_____ Purpose _____
Comments_____
_____

Signature:_____**Date:**_____

BILLING INFORMATION

Responsible Party: Name_____,_____,_____
(Last) (First) (MI)

Address:_____,_____,_____,_____
(Street Address) (City) (State) (Zip)

Phone: ( )_____ ( )_____ May we contact work?_____Yes_____No
(Home) (Work)

Birthdate:_____Employer:_____
(m/d/y) (Name) (Address)

Social Security #_____ Drivers License #_____

INSURANCE INFORMATION

Do you have Dental Insurance?_____Yes_____No Do you have two insurance carriers?_____Yes_____No

Primary Coverage
Employee Name: _____
Birthday: _____
Social Security #: _____
Employer: _____
Name of Ins. Co.: _____
Union Local: _____ Group #: _____

Secondary Coverage
Employee Name: _____
Birthday: _____
Social Security #: _____
Employer: _____
Name of Ins. Co.: _____
Union Local: _____ Group #: _____

Collection Costs and Reasonable Attorney's Fees: Any account more than 60 days in arrears I (we) will be subject to a 2.0% interest charge per month. If this account is not paid as agreed and the account is assigned to a third party collection agency. I (we) agree to pay the actual amount of any collection fee not to exceed 50% of the amount assigned. If this account is not paid as agreed, and legal action is commenced to collect the amount due, I (we) agree that, in addition to other charges authorized herein, I (we) will pay reasonable attorney's fees. _____**(Initial)**

Authorization to Pay Benefits to Dentist: I hereby authorize payment directly to the above named dentist of the group insurance benefits otherwise payable to me._____**(Initial)**

No Show Appointments: If no reasonable effort is made to contact the office 24 hours in advance to cancel an appointment, a $75 charge will be levied against the patient responsible._____**(Initial)**

Insurance payments: As a courtesy service, we will file your insurance claim form and any necessary supporting documents that may be needed to ensure the speedy processing of you claim. We encourage our patients to follow up on their insurance claims if there are any problems since insurance companies respond better to the subscriber, who pays the premiums, than the dental office, who is a third party. We can only ***estimate*** your patient portion based on the information you/we have on your particular plan_____**(Initial)** Payment of your patient portion is due at the time of visit. If we are unable to verify your eligibility and benefit levels at the time of the appointment, we ask that you pay the entire amount of treatment at the time of visit. Insurance portion estimates are based on the information we have been given on your plan. If the actual insurance payment differs from the estimate, you are responsible for the difference. Even if a predetermination of benefits has been received, the final amount paid by your insurance company may change. This amount is due to our office once final insurance payment has been received. If the discrepancy is in your favor, we will refund the difference, or you may choose to carry a credit balance to be used towards any future appointments._____**(Initial)**

Payment Options:

1. *Cash*--Includes money orders and personal checks
2. *Visa/Mastercard*-- We accept credit cards as payment for treatment to the extent your credit line permits.
3. *CareCredit*--Offers a separate line of credit to cover your entire family's health care needs
   * A credit line can be established and approval usually takes less than 10 minutes * CareCredit has an interest free option
   * There is no annual or membership fee * Monthly payments as low as 3% of the outstanding balance

Signature: _____ **Date:** _____

Comfort List

At Premier Dental Center we want to help our patients feel as relaxed and comfortable as possible! As we know, going to the dentist is not everyone's favorite place to be. Below you will find a list of items we offer to set you at ease. As always please let us know if there is anything beyond this to help make your visit more enjoyable. _____**(Initial)**

- ❑ Neck Pillow
- ❑ Lip Moisturizer (During treatment)
- ❑ Cozy Blanket
- ❑ Warm Hand Towels
- ❑ Headphones - Yours to keep!
- ❑ Cold Ice Packs
- ❑ Protective Eyewear
- ❑ Nitrous Oxide ($55 per hour)
- ❑ Other _____ .