FAMILY DENTAL

New Patient Registration Form

Who can we thank for referring you to our practice? _____

SECTION I: Patient Information

E-Mail Address: _____

First & Last Name: _____ Preferred Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Cell Phone: (_____)_____ Home Phone: (_____)_____ Work Phone: (_____)_____

Circle appropriate: Minor Single Married/Partner Separated/Divorced Widowed

Date of Birth: ____/____/_____ Soc. Sec. #: _____ State ID/License#:_____

Emergency Contact Name: _____ Phone: _____

Section II: Responsible Party Information

(If someone other than patient, and/or patient is under age 18)

First & Last Name: _____ Relationship to Patient: ___Self ___Spouse ___Child ___Other

Address: _____ City: _____ State: _____ Zip Code: _____

Cell Phone: (_____)_____ Home Phone: (_____)_____ Work Phone: (_____)_____

Date of Birth: ____/____/_____ Soc. Sec. #: _____ State ID/License#:_____

Section III: Insurance Information

Policy Holder Name: _____ Relationship to Patient: ___Self ___Spouse ___Child ___Other

Policy Holder Soc. Sec. #: _____ Policy Holder Date of Birth: ____/____/_____

Member ID#: _____Employer Name : _____ Group #_____

Additional Comments:

FAMILY DENTAL

MEDICAL HISTORY

PATIENT NAME _____ Date of Birth: ____/____/_____

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	
Do you need to pre-medicate?	Yes	No	If yes, please explain: _____

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?

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: _____

_____

_____

_____

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/GUARDIAN _____ **DATE** _____

FAMILY DENTAL

OFFICE POLICIES

Broken/Canceled Appointments: We are very appreciative of patients who arrive on time for their scheduled appointments. In the event you need to cancel an appointment, we request notice at least 48 hours in advance. As a courtesy, our office may contact you via email or phone to remind you of your appointment(s). While certain emergencies and other issues may be taken into consideration, Family Dental reserves the right to apply a fee of $50 per half-hour of the scheduled appointment for failure to provide adequate notice. Our other goal is to keep the cost of dental services as economical as possible. The appointment you schedule for treatment is reserved for you and your treatment only. When you fail to keep your appointment without providing us adequate notice, this adds to the overall cost of care, as trained professionals and dental facilities are not being utilized. We appreciate your understanding and consideration regarding or appointment policy and if you have any questions or concerns, never hesitate to ask us.

Guarantee of Payment/Assignment of Insurance Benefits: Unless otherwise stated, I understand that fees are due for any services rendered on the date of service. I authorize payment for services rendered to me to be made directly to this office for benefits otherwise payable to me. These payments shall not exceed the regular charges for this period of treatment. **I also understand that I am responsible to pay any charges not covered through my insurance benefits, including but not limited to non-covered services, applicable deductible and/or co- insurances as defined by my policy (ies) or, any fees for services in the event that I do not have insurance coverage.**

Completion of Treatment: In the event that I elect to receive treatments such as crowns, dentures, root canals, bridges, implants and other treatment that requires me to return for future visits to finalize, I understand that I am responsible to return to the office to complete treatment. These types of treatments typically require Family Dental to incur lab, equipment and labor costs up front. **In the event that I do not return to complete the treatment, I understand that I am still responsible to pay the full cost of the treatment.**

Past-Due Balances & Collection Services: Family Dental makes an effort to provide all patients with education and information regarding proposed and completed treatment as well as the costs associated, in order for each patient to make an informed decision regarding their treatment. Family Dental also participates in lending programs to extend interest-free credit to qualified applicants for certain procedure. However**, in the event that I do not pay outstanding balance(s), I understand that 12% interest rate will be applied to any past due balances on my account(s)**. I also understand that should my past due balance be referred to an attorney or collection agency, I will be financially responsible for any additional costs incurred such as attorney fees, collection agency fees, court costs, etc.

Patient Dismissal: Our practice takes pride in our dentistry and in the relationships with our patients who believe in quality care. Cooperation is a key element to successful treatment. Family Dental reserves the right to dismiss patients in the interest of customer service and quality care for all patients. Family dental will be happy to transfer patient records to another provider at the request and approval for any patients who are dismissed.

I agree to abide by the policies listed above. I understand that if I have any questions about these policies, I may request assistance and further explanation at any time from a Family Dental staff member.

_____ _____

Patient/Responsible Party Signature Date

_____ _____

Family Dental Staff Date

FAMILY DENTAL

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE
OF PRIVACY PRACTICES

I have received a copy of Family Dental's Notice of Privacy Practices.

Alternate Communications Information

Family Dental normally contacts patients using phone or email for appointment reminders, account information, pre-medication information, and other information pertaining to your treatment or account.

If you will need Family Dental to observe **alternate** methods to contact you other than what you have listed, please list them below, otherwise, leave this section blank:

___ Phone Number: _____ May we leave a message? ___ Yes ___ No

When leaving a message, please list your preference for how Family Dental identifies itself:

___ Family Dental of ____Dentist's Office ____ Other: _____

___Mailing Address: _____

___Other:_____

_____ _____
Patient/Guardian Signature Date

FOR OFFICE USE ONLY

_____ _____
Family Dental Staff Date

We attempted to obtain written acknowledgement of receipt of our Notice of Practice, but acknowledgement could not be obtained because:

___ Individual refusal to sign

___ Communications barrier prohibited the acknowledgement

___ An emergency situation prevented us from obtaining acknowledgement