Patient Registration

PATIENT INFORMATION:

First Name:_____ Last Name:_____ Middle Initial: _____
Address:_____ City:_____ State:_____ Zip Code: _____
Home Phone:_____ Work Phone:_____ Ext: Cell Phone: _____
Birthdate:_____ Social Security Number:_____ Email:_____
Sex: ☐ Male ☐ Female
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed
Employer:_____ Occupation: _____
Referred By: ☐ Family/Friend: _____ ☐ Google ☐ Facebook ☐ Mail ☐ Event
☐ Insurance Company ☐ Other: _____
Previous Dentist: _____
Emergency Contact: _____ Relationship to patient: _____
Emergency Contact Phone Number: _____ Preferred Pharmacy: _____

RESPONSIBLE PARTY:

Patient? Y / N First Name: _____ Last Name: _____ Middle Initial: _____
Relation to patient: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Home Phone: _____ Work Phone: _____ Ext: _____ Cell Phone: _____
Birthdate: _____ Social Security Number: _____ Email: _____
Employer: _____ Occupation: _____

PRIMARY INSURANCE INFORMATION:

Dental Insurance Company: _____
ID Number/Member ID: _____
Policy Holder's Name: _____
Policy Holder's Birthdate: _____
Policy Holder's SSN: _____
Policy Holder's Employer: _____
Policy Holder's Address: _____
Policy Holder's Zip Code: _____

SECONDARY INSURANCE INFORMATION:

Dental Insurance Company: _____
ID Number/Member ID: _____
Policy Holder's Name: _____
Policy Holder's Birthdate: _____
Policy Holder's SSN: _____
Policy Holder's Employer: _____
Policy Holder's Address: _____
Policy Holder's Zip Code: _____

In Office Signatures:

I have read and understand the Notice of Privacy Practices and Authorization (HIPPA).

Signature: _____ Relationship to patient: _____ Date: _____

I give my consent to Dental Renaissance to notify/contact me via unencrypted email or text which may include personal health information. (ex: appointment reminders, notifications)

Signature: _____ Date: _____
Relationship to patient: _____

Medical History

Patient Name: _____ **Birthdate**: _____

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.

If you answer yes to the following questions, please explain on the blank provided.	YES	NO
Are you under a physician's care now? _____	☐	☐
Have you ever been hospitalized or had a major operation? _____	☐	☐
Have you ever had a serious head or neck injury? _____	☐	☐
Are you taking any medications, pills, or drugs? _____	☐	☐
If yes, please provide a MED LIST: _____	☐	☐
Do you take, or have you taken Phen-Fen or Redux? _____	☐	☐
Have you ever taken Fosamax, Boniva, Actonel, or any other medication containing bisphosphonates? _____	☐	☐
Are you on a special diet? _____	☐	☐
Do you use tobacco? _____	☐	☐
Do you use controlled substances? _____	☐	☐

* Women, are you: (circle all that apply) Pregnant Trying to get pregnant Taking oral contraceptives Nursing

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthestics ☐ Acrylic ☐ Metal ☐ None

☐ Latex ☐ Sulfa Drugs ☐ Other If yes, please explain: _____

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

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

Have you ever had any serious illness not listed above:

_____

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

Signature of Patient, Parent, or Guardian: _____ Date: _____

Doctor Signature: _____ Date: _____

Dental History

Name: _____

How would you rate the condition of your mouth? Excellent Good Fair Poor

Previous Dentist:_____How long have you been a patient? _____

Date of most recent dental exam:_____Date of most recent x-rays: _____

Date of most recent treatment (other than cleaning): _____

I routinely see the dentist every: 3 months 4 months 6 months 12 months Not routinely

What is your immediate concern? _____

Please answer YES or NO to the following:

Personal History

Y / N

1. Are you fearful of dental treatment? How fearful on a scale of 1 (least) to 10 (most)?_____ ☐ ☐
2. Have you had an unfavorable dental experience? _____ ☐ ☐
3. Have you had complications from past dental treatment?_____ ☐ ☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic?_____ ☐ ☐
5. Did you ever have braces, orthodontic treatment or have your bite adjusted? _____ ☐ ☐
6. Have you had any teeth removed? _____ ☐ ☐

Smile Characteristics

1. Is there anything about the appearance of your teeth you would like to change? _____ ☐ ☐
2. Have you ever whitened (bleached) your teeth? _____ ☐ ☐
3. Have you felt uncomfortable or self-conscious about the appearance of your teeth?_____ ☐ ☐
4. Have you been disappointed with the appearance of previous dental work?_____ ☐ ☐

Bite & Jaw Joint

1. Do you have problems with your jaw joint? (pain, sounds, limited opening, lock popping) _____ ☐ ☐
2. Do you/would you have any problems chewing gum?_____ ☐ ☐
3. Do you/would you have any problems chewing bagels, baguettes, protein bars, or, other hard foods?_____ ☐ ☐
4. Have your teeth changed in the last 5 years, become shorter, thinner or worn?_____ ☐ ☐
5. Are your teeth crowding or developing spaces?_____ ☐ ☐
6. Do you have more than one bite and squeeze to make your teeth fit together?_____ ☐ ☐
7. Do you chew ice, bite your nails, use your teeth to hold objects or have any other oral habits? _____ ☐ ☐
8. Do you clench your teeth in the daytime or do they become sore? _____ ☐ ☐
9. Do you have any problems with sleep or wake up with an awareness of your teeth? _____ ☐ ☐
10. Do you wear or have you ever worn a bite appliance?_____ ☐ ☐

Tooth Structure

1. Have you had any cavities within the past 3 years?_____ ☐ ☐
2. Does the amount of saliva in your mouth seem too little or do you have any difficulty swallowing any food?_____ ☐ ☐
3. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?_____ ☐ ☐
4. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?_____ ☐ ☐
5. Do you have any grooves or notches on your teeth near the gum line?_____ ☐ ☐
6. Have you ever had broken teeth, chipped teeth, or had a toothache, or cracked filling? _____ ☐ ☐
7. Do you frequently get food caught between any teeth? _____ ☐ ☐

Biology

1. Do your gums bleed or are they painful when brushing or flossing?_____ ☐ ☐
2. Have you ever been treated for gum disease or been told you have lost bone around your teeth?_____ ☐ ☐
3. Have you ever noticed an unpleasant odor in your mouth? _____ ☐ ☐
4. Is there anyone with a history of periodontal disease in your family? _____ ☐ ☐
5. Have you ever noticed gum recession?_____ ☐ ☐
6. Have you ever had any teeth become loose on their own (no injury), or do you have difficulty eating an apple?_____ ☐ ☐
7. Have you experienced a burning sensation in your mouth?_____ ☐ ☐

Financial Policy

We are committed to providing you with the best dental care. Our fees reflect our professional commitment to excellence. Payment in full is expected at the time of service. If you have dental insurance, we are happy to help you receive your maximum allowable benefit. To achieve these goals, we need your assistance and understanding of our payment policy. For your convenience, we offer a wide range of financial options to pay for your dental treatment:

A) Split Payment

Half of the total treatment is due at the preparation visit and the second half is due the day of cementation of the crown(s), bridge(s), veneer(s), etc.

B) Pay as You Go

You may choose to pay your obligation for each visit with cash, check or credit card at the visit.

C) Prepayment in Full

For any treatment over $2,000, a prepayment bookkeeping courtesy of 5% will be given for direct payment in full by cash or check before or after the first treatment visit.

D) Care Credit

Care Credit offers No Interest financing for up to 24 months and low monthly payment options. There are no up-front costs, prepayment penalties or fees if it is paid in full by the end of the term. This allows you to get the necessary treatment completed now and pay later.

E) Proceed Finance

Proceed Finance offers a variety of financing options. There are no up-front costs, prepayment penalties or fees if it is paid in full by the end of the term. This allows you to get the necessary treatment completed now and pay later.

FORMS OF PAYMENT ON BALANCES DUE

To facilitate access to the very best dental care possible, you may choose from any of the following: Cash, Visa, MasterCard, American Express, Discover, Personal Checks or Care Credit (see above).

Interest of 1.5% per month will be charged on any unpaid balance after 60 days. This allows sufficient time for your insurance carrier to make payment. By law, insurance companies are required to make payment or deny a claim within 30 days. Please be aware that your dental benefit program is a contract between you, your employer, and the insurance company. We are not a party to that contract. We file insurance claims as a courtesy to you, our valued patient. You are responsible (not your insurance company) for all fees for services rendered. We will gladly assist you in any way we can.

I understand that if I become delinquent on my account, my account will be turned over to a collection agency and I will subsequently be reported to the credit bureaus. In case of total default, I agree to pay all costs for collection including but not limited to interest, court costs, sheriff fees, attorney fees and collection costs that may be incurred to collect on this account.

Please be aware that any parent or guardian bringing a child to our office is legally responsible for the payment of services rendered.

After your dental insurance has paid for dental services rendered at Dental Renaissance, you may have an outstanding balance. This balance may include any deductibles, copayments, denials, and non-covered services. We do our best to estimate what you will owe. For balance owed, we will require a credit card authorization, or you may need to pay your entire balance up-front.

Credit Card (check one): ☐ Visa ☐ MasterCard ☐ Discover ☐ Amex ☐ CareCredit

Card #: _____ Expiration Date: _____ CVV #: _____

Card Holder Signature: _____

Billing Address: _____ State: _____ Zip: _____

I certify that I have read, fully understand, and accept the above financial policy.

Name of patient or responsible party**:** _____ **Signature:** _____

Appointment Policy

We feel that our patients' time is valuable. We require a minimum of 48hrs notice if you must change an appointment. This courtesy allows our staff adequate time to fill the appointment with another patient in need of dental care. Failure to give 48hrs notice will result in a $75 fee. We appreciate your understanding and commitment to avoid this scenario.

Signature of patient or responsible party: _____ Date: _____