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## PATIENT REGISTRATION FORM

We are pleased to welcome you to our practice. Please complete the following information thoroughly. We look forward to working with you in maintaining your dental health.

Today's Date: \* \_\_\_\_\_

Chart#: \_\_\_\_\_  
FOR OFFICE USE ONLY

Patient Name: \_\_\_\_\_

Last

First

M

Preferred Name

Title: \_\_\_\_\_ Gender:  Male  Female Family Status:  Married  Single  Child  Other  
Mr/Ms/Mrs/etc

Birth Date: \_\_\_\_\_

SS#: \_\_\_\_\_

Prev. Visit: \_\_\_\_\_

Email Address: \_\_\_\_\_ Best time to call: \_\_\_\_\_

Phone: \_\_\_\_\_  
Home Mobile Work Ext Fax Other

Address: \_\_\_\_\_  
Address 1 Address 2  
City State Zip Code

Are you a seasonal patient?  Yes  No

If seasonal please list which months in Naples.

How did you hear about our practice?

In an emergency who should be notified? Please enter Name and Phone number below:

Emergency Contact Name and number \*

Relationship to Patient: \_\_\_\_\_



## Consent for Services and Financial Policy

### FINANCIAL POLICY

Our mission is to deliver the finest dental care available today. Fine dentistry is truly an investment; our goal is to help you make that investment possible. We are a fee per service practice; payment is due at the time dental services are rendered. Our practice is not an insurance provider. Patients with dental insurance will be provided with a completed claim form at checkout to submit to their insurance company for reimbursement based on their plan benefits. Please bring a copy of your dental insurance card, so that a claim form may be provided. Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all services. Please remember insurance is a contract benefit between patient and the insurance company.

The following payment options are available for your convenience; check, cash, credit cards (Visa, MasterCard or Discover.) If you are paying by cash or check for treatments over \$1,500 please ask about our pre-payment discount, when you pay in advance of your appointment.

Flexible monthly payment plans are available through Care Credit. Applications for Care Credit are available in our office or you may apply online at [CareCredit.com](http://CareCredit.com)

Treatment Plans presented for dental care can only be extended for a period of 3 months from the date of the patient examination and diagnosis. This is due to the fact that if left untreated, condition may worsen and may require more extensive treatment.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment.

### APPOINTMENTS

We understand that an unforeseen emergency may arise at any time. Please be advised that in the event you have to re-schedule an appointment we ask for the courtesy of at least 24 to 48 hours advance notice, so that we may offer the time to another patient. We also reserve the right to charge a missed appointment charge of \$50.00 if our office was not given advance notice or for 'no-shows.' We thank you in advance for your understanding in respecting the practice's time. As a courtesy we will text/email you appointment reminders in advance and we mail reminder post cards for all our hygiene appointments. We respectfully ask that you please confirm your appointments.

By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the Registration Form.

Signature \_\_\_\_\_ Date \_\_\_\_\_

## HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,

I allow this practice to disclose my Protective Health Information to the following individuals: (This information could include: Name, Diagnosis, Test Results, Images and Account Information.)

**Name and Relationship to Patient:**

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**Name and Relationship to Patient:**

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By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Response Date:** \_\_\_\_\_

**MEDICAL & DENTAL HISTORY FORM**

**Patient Name:** \_\_\_\_\_  
Last First M Preferred Name

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well-being.

**Would you consider yourself to be in fairly good health?**  Yes  No

**Within the past year, have there been any changes in your general health?**  Yes  No

**What is the date (or approximate date) of your last medical exam?**

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**Your Primary Care Physician's name, address, & phone number:**

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**Please mark any of the following to indicate Yes in response to the question:**

- Have you ever had complications following dental treatment?
- Are you currently under the care of a physician due to a specific condition?
- Have you been hospitalized within the last 5 years due to a surgery or illness?
- Are you currently taking any prescription or non-prescription medications?
- Do you use tobacco (smoking or chewing)?
- Do you require the use of corrective lenses (contacts or glasses)?
- Do you have any other conditions, diseases, etc., not listed above that we should be aware of?

**If any of the previous questions are marked, please explain:**

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**What is the reason for your dental visit today?**

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**When was your last visit to the dentist (if to a different office)?**

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What was done on your last dental visit (if to a different office)?

Prior Dentist's name, address, & phone number:

How frequently do you floss your teeth?

1 (+) a day    2 - 6 weekly    Monthly    Seldom    Never

Please list any medications you are currently taking, one medication per line:

Please indicate if you have experienced any of the following:

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> *NONE                | <input type="checkbox"/> Allergies            | <input type="checkbox"/> Allergy - Aspirin    | <input type="checkbox"/> Allergy - Bactrim    |
| <input type="checkbox"/> Allergy - Cat Dander | <input type="checkbox"/> Allergy - Codeine    | <input type="checkbox"/> Allergy - Cycline's  | <input type="checkbox"/> Allergy - Dyes       |
| <input type="checkbox"/> Allergy - Erythro    | <input type="checkbox"/> Allergy - Floxin     | <input type="checkbox"/> Allergy - Furadantin | <input type="checkbox"/> Allergy - Gluten     |
| <input type="checkbox"/> Allergy - Hay Fever  | <input type="checkbox"/> Allergy - Iodine     | <input type="checkbox"/> Allergy - Latex      | <input type="checkbox"/> Allergy - Morphine   |
| <input type="checkbox"/> Allergy - Other      | <input type="checkbox"/> Allergy - Penicillin | <input type="checkbox"/> Allergy - Sulfa      | <input type="checkbox"/> Allergy -Clindamycin |
| <input type="checkbox"/> Allergy-Amoxicillin  | <input type="checkbox"/> Anemia               | <input type="checkbox"/> Anesthesia Sensitivi | <input type="checkbox"/> Arthritis            |
| <input type="checkbox"/> Artificial Joints    | <input type="checkbox"/> Asthma               | <input type="checkbox"/> Balck Plague Serum   | <input type="checkbox"/> Blood Disease        |
| <input type="checkbox"/> Blood Thinner        | <input type="checkbox"/> Cancer               | <input type="checkbox"/> COPD                 | <input type="checkbox"/> Diabetes             |
| <input type="checkbox"/> Dizziness            | <input type="checkbox"/> Epilepsy             | <input type="checkbox"/> Excessive Bleeding   | <input type="checkbox"/> Factor 5 Deficiency  |
| <input type="checkbox"/> Fainting             | <input type="checkbox"/> Fractured Ankle      | <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Head Injuries        |
| <input type="checkbox"/> Headaches            | <input type="checkbox"/> Heart Disease        | <input type="checkbox"/> Heart Murmur         | <input type="checkbox"/> Hepatitis            |
| <input type="checkbox"/> High Blood Pressure  | <input type="checkbox"/> Hip Revision         | <input type="checkbox"/> HIV                  | <input type="checkbox"/> Jaundice             |
| <input type="checkbox"/> Kidney Disease       | <input type="checkbox"/> Liver Disease        | <input type="checkbox"/> Low Blood Pressure   | <input type="checkbox"/> Mental Disorders     |
| <input type="checkbox"/> Nervous Disorders    | <input type="checkbox"/> Other                | <input type="checkbox"/> Pacemaker            | <input type="checkbox"/> Pregnancy            |
| <input type="checkbox"/> Radiation Treatment  | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Rheumatic Fever      | <input type="checkbox"/> Rheumatism           |
| <input type="checkbox"/> Sinus Problems       | <input type="checkbox"/> Stomach Problems     | <input type="checkbox"/> Stroke               | <input type="checkbox"/> Thyroid Problems     |
| <input type="checkbox"/> Tuberculosis         | <input type="checkbox"/> Tumors               | <input type="checkbox"/> Ulcers               | <input type="checkbox"/> Venereal Disease     |

Do you have any other health issues or allergies?  Yes  No

If YES, please list below

Are you required to PRE-MEDICATE prior to dental procedures? \*  Yes  No

Do you take BLOOD THINNER medication? \*  Yes  No

WOMEN ONLY: Are you pregnant?  Yes  No

If Yes, when is the due date? \_\_\_\_\_

Please mark any of the following to indicate Yes in response to the question:

- Do your gums bleed when you brush or floss?
- Do your teeth experience sensitivity to cold or hot temperatures?
- Are any of your teeth currently causing you pain?
- Do you grind your teeth (either consciously or during sleep)?
- Are any of your teeth loose, or are you concerned about any teeth loosening?
- Do you currently have any dental implants, denturés, or partials?

If any of the previous questions are marked, please explain:

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If you could change anything about your mouth, teeth, or smile, what would it be?

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To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next dental appointment without fail.

**Authorization**

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Signature of patient, parent, or guardian:

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Relationship to Patient:**

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**FOR OFFICE USE ONLY**

DR SIGNATURE ONLY

Signature \_\_\_\_\_ Date \_\_\_\_\_

Response Date: \_\_\_\_\_