

NEW PATIENT REGISTRATION FORM

PATIENT INFORMATION

Name _____

Last Name

First Name

Middle Initial

Address _____

City _____ State _____ Zip _____

Social Security # _____ Sex _____ Age _____ Date of Birth _____

Married ___ Widowed ___ Single ___ Minor ___ Separate ___ Divorced ___ Partnered ___

Whom may we thank for referring you? _____

Contact Information:

Home _____ Mobile _____ Work _____ Ext _____

E-mail _____

Patient Employer/ School _____

Occupation _____ Employer/ School Phone _____

Employer/ School Address _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Cell Phone (____) _____ Home Phone (____) _____

DENTAL INSURANCE INFORMATION

No Insurance _____

Primary Dental Plan Name _____ Group # _____

Subscriber's Name _____ Date of Birth _____

Relationship to patient _____

Secondary Dental Plan Name _____ Group # _____

Subscriber's Name _____ Date of Birth _____

Relationship to patient _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have Insurance coverage with _____ and
(Name of Insurance Company/ies)

assign directly to **Family Smile Dental Center** all insurance benefits, if any, otherwise payable to me for services rendered.

I authorize the use of my signature on all insurance submissions.

I understand that copies of claims and/or insurance payments should be requested directly by me to the insurance company.

I understand that I am financially responsible for all charges whether or not paid by insurance

I understand that my insurance plan may have a maximum amount per year. Whereas this office may help me keeping an estimate of it, it will be my responsibility to contact the insurance company for more accurate and up to date information

Signature of Patient, Parent, Guardian or Personal Representative

Relationship to Patient

Print name of Patient, Guardian or Personal Representative

Date

DENTAL HISTORY

Patient name: _____ **Date of Birth:** _____

Reason for Today's visit _____

Date of last dental visit _____ Date of last dental X-rays _____ Date of last dental cleaning _____

Former Dentist _____ Phone: _____

How often do you floss? _____ How often do you brush your teeth? _____

Place a mark on "yes " or "no" to indicate if you have any of the following:

	YES	NO		YES	NO		YES	NO		YES	NO
Bad breath			Bleeding gums			Blisters on lips or mouth			Burning sensation on tongue		
Chew on one side			Clicking or popping jaw			Dry mouth			Jaw pain or tiredness		
Food collection between teeth			Grinding teeth			Swollen or tender gums			Mouth breathing		
Lip or cheek biting			Loose teeth			Broken fillings			Periodontal treatment		
Mouth pain on brushing			Orthodontic treatment			Pain around ear			Sensitivity when biting		
Sensitivity to cold			Sensitivity to heat			Sensitivity to sweets			Sores or growths in your mouth		

MEDICAL HISTORY

Pharmacy's Name and Phone Number: _____

Have you ever been hospitalized or had a major operation? YES NO If yes, explain: _____

Have you ever had a serious head or neck injury? YES NO _____

Do you have Artificial Joints? YES NO If yes, Where: _____ Surgery Date _____

Have you been instructed/required to pre-medicate prior to a dental procedure YES NO If yes, explain: _____

Have taken, Fen-phen or Redux? YES NO

Do you use tobacco? YES NO Do you snore? YES NO

For women: Are you pregnant? YES NO Due Date: _____ Are you nursing? YES NO

Place a mark on "yes " or "no" to indicate if you have or have had any of the following:

	YES	NO		YES	NO		YES	NO		YES	NO
AIDS/HIV Positive			Epilepsy or Seizures			High Blood Pressure			Rheumatism		
Alzheimer's Disease			Excessive Bleeding			High Cholesterol			Scarlet Fever		
Anemia			Fainting/Dizziness			Hives or Rash			Shingles		
Arthritis/Gout			Frequent Cough			Hypoglycemia			Sinus Trouble		
Artificial Heart Valve			Frequent Headaches			Irregular Heartbeat			Sleep disorder		
Asthma			Glaucoma			Kidney Disease			Stomach/Intestinal Disease		
Blood Disease			Heart Attack/Failure			Liver Disease			Stroke		
Cancer			Heart Murmur			Low Blood Pressure			Swelling of Limbs		
Chemotherapy			Heart Pacemaker			Lung Disease			Thyroid Disease		
Cold Sores/Fever Blisters			Heart Trouble/Disease			Mental Health Disorder			Tonsillitis		
Congenital Heart Disorder			Hemophilia			Mitral Valve Prolapse			Tuberculosis		
Convulsions			Hepatitis A			Pain in Jaw Joints			Tumors /Growths		
Cortisone Treatments			Hepatitis B or C			Radiation			Ulcers		
Diabetes			Herpes			Rheumatic Fever			Venereal Disease		
Other condition(s):											

MEDICATIONS		ALLERGIES	
List all your medications and supplements	No Medications _____	Aspirin _____	Not known drug allergies _____
_____		Codeine _____	
_____		Iodine _____	
_____		Latex _____	
_____		Local Anesthetic _____	
_____		Penicillin _____	
_____		Sulfa _____	
_____		Other: _____	

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 change in medical status.

SIGNATURE OF PATIENT, PARENT, or

GUARDIAN _____ **DATE** _____

FAMILY SMILE DENTAL CENTER POLICIES

I hereby agree that **Family Smile Dental Center** may use my health care information and may disclose such information to the insurance company(ies) and their agents for the purpose of obtaining payments for services and determining insurance benefits or the benefits payable for related services. I authorize the use of my signature on all insurance submissions.

I understand that my insurance plan may have a maximum amount per year. Whereas this office may help me keeping an estimate of it, it will be my responsibility to contact the insurance company for more accurate and up to date information.

I understand that I am ultimately financially responsible for all charges whether or not they are covered by the insurance plan.

Copies of claims and/or insurance payments should be requested directly by me to the insurance company.

In the event a patient's account is placed in the hands of an attorney, or collection agency, the patient's account will be charged a collection fee that is 33.5% of their total account balance.

I have read the office Notice of Privacy Practices

I understand that there will be a \$35.00 processing fee for any dishonored or returned check.

All appointments must be scheduled in advance. A \$60.00 NO SHOW or LATE CANCELLATION fee will apply if I do not cancel my appointment 48 Business hours prior to my appointment.

AUTHORIZATION TO DISCUSS DENTAL, HEALTH AND ACCOUNT INFORMATION

We require written authorization to release and/or discuss dental, health and account information to anyone other than the patient and/or legal guardian.

I do NOT give permission to discuss my dental, health and/or account information with anyone.

I give the doctors and staff of FAMILY SMILE DENTAL CENTER permission to discuss my dental, health and account information with:

Please list name(s)

Name: _____ Relationship to pt. _____ Phone #: _____

Name: _____ Relationship to pt. _____ Phone #: _____

AUTHORIZATION TO LEAVE MESSAGES

I give the doctors and staff of FAMILY SMILE DENTAL CENTER authorization to leave messages on:

Home phone: _____ Cell Phone: _____ Work phone: _____

I have read and fully understand the office and HIPPA policies; I agree to be personally and fully responsible.

Signature of Patient, Parent or Legal Guardian: _____ Patient name _____

Date: _____

FLUORIDE VARNISH CONSENT FORM

As a preventive dental service program, FAMILY SMILE DENTAL CENTER is offering the treatment of a protective coating called Fluoride Varnish. This treatment should be applied immediately following a professional cleaning. The American Dental Association recommends application of fluoride varnish for patients who fall into moderate risk to high-risk group for dental decay and tooth sensitivity. All patients can benefit from fluoride varnish.

You will be considered at risk for dental decay if you had a cavity within the last 3 years or have one of the following risks factors:

- Sensitivity to hot, cold or to certain foods
- Have "dry mouth"
- Have or are being treated for acid reflux
- Consume food high in sugars
- Drink carbonated beverages
- Are under active orthodontic (braces or Invisalign) treatment
- Have many multisurface (large) fillings or crowns
- Have gum recession and root exposure

Dental Insurances policies vary on frequency and coverage for fluoride varnish. The fee for fluoride application without dental insurance coverage is **\$30.00**

By signing below, I am acknowledging that I have read the above service available. At this time, I elect to:

Have fluoride varnish applied even if my insurance does NOT pay for it.

Have fluoride varnish applied only if my insurance plan covers it.

I choose not to have fluoride varnish.

Patient's Name: _____ Date: _____

Signature of patient, parent or legal guardian: _____