



**Patient Registration**

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

**Date of Birth:** \_\_\_\_\_

If a Child, Parent's Name: \_\_\_\_\_

**Social Security #:** \_\_\_\_\_

**Street Address:** \_\_\_\_\_

**City:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_

**State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

**Work Phone:** \_\_\_\_\_

**Patient Employer:** \_\_\_\_\_

**Cell phone:** \_\_\_\_\_

**Present Position:** \_\_\_\_\_

**Email:** \_\_\_\_\_

*In Case of Emergency Who Should be Notified?* \_\_\_\_\_

*Phone:* \_\_\_\_\_

How were you referred to our office?  Insurance Listing  Website  Facebook  Flyer  
 Patient: \_\_\_\_\_  Other: \_\_\_\_\_

**Medical History**

Name of Primary Care Provider: \_\_\_\_\_ Phone: \_\_\_\_\_

**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:** \_\_\_\_\_

**Are you taking any blood thinners?**  Yes  No

Are you on a special diet?  Yes  No

Do you use tobacco?  Yes  No

Do you use controlled substances?  Yes  No

Women- Are you: Pregnant/Trying to get pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No Taking oral contraceptives? <input type="checkbox"/> Yes <input type="checkbox"/> No Nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No
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**Are you allergic to any of the following?**  Yes  No

Aspirin  Penicillin  Codeine  Acrylic  Metal  Latex  Local Anesthetics  
 Other

If yes, please explain: \_\_\_\_\_

**Do you have, or have you had, any of the following?**  Yes  No

- |                                                 |                                                    |                                              |                                                     |
|-------------------------------------------------|----------------------------------------------------|----------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> AIDS/HIV Positive      | <input type="checkbox"/> Cortisone Medicine        | <input type="checkbox"/> Hemophilia          | <input type="checkbox"/> Renal Dialysis             |
| <input type="checkbox"/> Alzheimer's Disease    | <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> Hepatitis A         | <input type="checkbox"/> Rheumatic Fever            |
| <input type="checkbox"/> Anaphylaxis            | <input type="checkbox"/> Drug Addiction            | <input type="checkbox"/> Hepatitis B or C    | <input type="checkbox"/> Rheumatism                 |
| <input type="checkbox"/> Anemia                 | <input type="checkbox"/> Easily Winded             | <input type="checkbox"/> Herpes              | <input type="checkbox"/> Scarlet Fever              |
| <input type="checkbox"/> Angina                 | <input type="checkbox"/> Emphysema                 | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Shingles                   |
| <input type="checkbox"/> Arthritis/Gout         | <input type="checkbox"/> Epilepsy or Seizures      | <input type="checkbox"/> High Cholesterol    | <input type="checkbox"/> Sickle Cell Disease        |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Excessive Bleeding        | <input type="checkbox"/> Hives or Rash       | <input type="checkbox"/> Sinus Trouble              |
| <input type="checkbox"/> Artificial Joint       | <input type="checkbox"/> Excessive Thirst          | <input type="checkbox"/> Hypoglycemia        | <input type="checkbox"/> Spina Bifida               |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Blood Disease          | <input type="checkbox"/> Frequent Cough            | <input type="checkbox"/> Kidney Problems     | <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> Blood Transfusion      | <input type="checkbox"/> Frequent Diarrhea         | <input type="checkbox"/> Liver Disease       | <input type="checkbox"/> Swelling of Limbs          |
| <input type="checkbox"/> Breathing Problem      | <input type="checkbox"/> Frequent Headaches        | <input type="checkbox"/> Low Blood Pressure  | <input type="checkbox"/> Thyroid Disease            |
| <input type="checkbox"/> Bruise Easily          | <input type="checkbox"/> Genital Herpes            | <input type="checkbox"/> Lung Disease        | <input type="checkbox"/> Tonsillitis                |

- |                                                    |                                                |                                                |                                            |
|----------------------------------------------------|------------------------------------------------|------------------------------------------------|--------------------------------------------|
| <input type="checkbox"/> Cancer                    | <input type="checkbox"/> Glaucoma              | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tuberculosis      |
| <input type="checkbox"/> Chemotherapy              | <input type="checkbox"/> Hay Fever             | <input type="checkbox"/> Pain in Jaw Joints    | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Chest Pains               | <input type="checkbox"/> Heart Attack/Failure  | <input type="checkbox"/> Parathyroid Disease   | <input type="checkbox"/> Ulcers            |
| <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Heart Murmur          | <input type="checkbox"/> Psychiatric Care      | <input type="checkbox"/> Venereal Disease  |
| <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Heart Pace Maker      | <input type="checkbox"/> Radiation Treatments  | <input type="checkbox"/> Yellow Jaundice   |
| <input type="checkbox"/> Convulsions               | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Recent Weight Loss    |                                            |

**Have you ever had any serious illness not listed above?**  
 explain \_\_\_\_\_

Yes  No **If yes, please**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**



**Aesthetic Family  
 Dentistry of Columbia**  
 Karlene M. Wright, D.D.S.

**Smile Assessment** - Please indicate if any of the following apply to you with a ✓

<input type="checkbox"/> Are you happy with the appearance of your teeth?	<input type="checkbox"/> Are your teeth sensitive to hot or cold?	<input type="checkbox"/> Do you have unsightly crowns or fillings?	<input type="checkbox"/> Do your gums bleed when brushing or flossing?	<input type="checkbox"/> Are you interested in whitening your teeth?
<input type="checkbox"/> Do you grind your teeth?	<input type="checkbox"/> Are you taking any medications for Osteoporosis?	<input type="checkbox"/> Are you missing teeth?	<input type="checkbox"/> Are you anxious or fearful of treatment?	<input type="checkbox"/> Have you had orthodontic work (braces)?
<input type="checkbox"/> Do you have recurrent headaches?	<input type="checkbox"/> Do you have any jaw pain?	<input type="checkbox"/> Are you interested in replacing missing teeth?	<input type="checkbox"/> Have you ever pre-medicated with antibiotics before dental procedures?	<input type="checkbox"/> Are you interested in straightening crowded or crooked teeth?

Please feel free to further explain any answers:  
 \_\_\_\_\_  
 \_\_\_\_\_

**Written Financial Policy**

Thank you for choosing Aesthetic Family Dentistry of Columbia. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options:

- We accept Cash, Debit, Visa, MasterCard, Discover, American Express, Apple Pay and Samsung Pay
- Convenient Interest-Free Monthly Payment Plans available from Care Credit (subject to credit approval)

**Aesthetic Family Dentistry of Columbia requires payment for services on the day services are rendered.** For larger, more comprehensive treatment plans of \$500 or more, a 20% deposit may be required to secure your initial treatment appointment.

Please provide at least 48 hours advance notice if you are unable to keep your scheduled appointment. This will enable us to offer your cancelled time to other patients. Your phone call is critical in helping us provide continuous care to all of our valued patients. **Please call our office at least 48 hours in advance in order to avoid being charged a missed appointment fee of \$50 per hour scheduled.**

**SIGNATURE ON FILE**

I authorize the use of this form on all my insurance submissions.  
 I authorize release of my information to all my Insurance Companies.  
 I understand that I am responsible for my bill  
 I have read and agree to the Financial Policy & Insurance Policy listed above  
 I authorize my doctor to act as my agent in helping me obtain payment from my Insurance Company.  
 I authorize payment directly to my doctor.  
 I permit a copy of this authorization to be used in place of the original.  
 My signature also applies to the dependents listed at the right.

**Dependent(s)**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Responsible Party Signature \_\_\_\_\_

Date \_\_\_\_\_



**Aesthetic Family  
Dentistry of Columbia**  
Karlene M. Wright, D.D.S.

**Dental Insurance Information**

**Covered Employee (Subscriber):**

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

Employer: \_\_\_\_\_

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

Insurance Company: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Insurance Company Phone #: \_\_\_\_\_

Member ID #: \_\_\_\_\_

Group #: \_\_\_\_\_

**Office Policy Regarding Dental Insurance**

The staff at Aesthetic Family Dentistry of Columbia is happy to work with your insurance carrier to maximize your benefit and directly bill them for reimbursement for your treatment. We must emphasize that this is only an estimate and all charges you incur are your responsibility regardless of your insurance coverage. Insurance companies have a wide variety of rules, plan limitations and exclusions that our office may not be aware of. We suggest that you review your dental policy so that you may be aware of specific limitations of your dental contract. Please note that you are responsible for all fees not covered by your insurance plan. Our office staff will do their best to provide you with an accurate estimate of these expenses which include deductibles and copayments at the time of service. For patients enrolled in dental PPO's, in order for us to offer premium service at substantial discounts, we require payment of deductibles and copayments at the time of service. Your insurance policy is a contract between you and your insurance company. Our office is not a party to that contract. We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Once insurance has paid their share, a statement will be sent to you for any remaining balance and will be due upon receipt. If your insurance company has not made payment within 60 days, the unpaid balance becomes your responsibility and is subject to finance charges and the collection process.

**Effective September 3, 2013, all accounts that are 60 days past due will be assessed a late fee of 2% of the balance due per month in addition to the existing balance unless other financial arrangements have been made. All accounts that are 90 days past due without payment may be assessed a \$20 fee and sent to a collection agency. There is a \$35 fee for all returned checks.**

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I authorize release of my information to all my Insurance Companies.  
I understand that I am responsible for my bill  
I have read and agree to the Financial Policy & Insurance Policy listed above  
I authorize my doctor to act as my agent in helping me obtain payment from my Insurance Company.  
I authorize payment directly to my doctor.  
I permit a copy of this authorization to be used in place of the original.  
My signature also applies to the dependents listed at the right.

**Dependent(s)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Responsible Party Signature \_\_\_\_\_

Date \_\_\_\_\_



**Patient Consent**

1. I do authorize and give consent to AFDOC, the dentist and his/her staff to administer treatment, including but not limited to local anesthesia and other such treatment, which in their judgment, may be necessary for the prudent exercise of medical or dental care. I understand that the use of medications, anesthetics, and some procedures embody a certain risk.
2. I acknowledge that no guarantee or assurance has been given by anyone as to the results that may be obtained.
3. I understand that during the procedure(s) unforeseen conditions may arise that necessitate different procedures from those planned. I consent to the performance of additional procedures that are deemed necessary in the professional judgment by the dentist and I understand that payment for these additional procedures is my responsibility.
4. I consent to the disposal of any tissues or teeth that may be removed.
5. The attached medical and dental history was completed fully and accurately to the best of my knowledge.
6. I understand responsibility for payment of dental services provided in this office for myself or my dependent(s) is mine. Unless other arrangements are made prior to treatment, accounts are to be paid on the day of services are provided. I have read and understand Aesthetic Family Dentistry of Columbia's financial policy.
7. I understand that I must be present for all scheduled appointments for my dependent(s) under the age of 18.
8. I hereby authorize payment of my group benefits, otherwise payable to me, to Aesthetic Family Dentistry of Columbia. In the event of legal action of this account, I agree to pay any and all costs of such suit, collection and attorney fees. I have reviewed the treatment plan and authorize the release of any information relative to this claim.
9. I grant my permission to you or your assignees to telephone me at the number(s) designated in my registration or email me to discuss matters related to this consent, my treatment, or account.
10. I have had the opportunity to review Aesthetic Family Dentistry of Columbia's Notice of Privacy Practices.
11. I understand that if I am unable to keep my appointment, I need to let Aesthetic Family Dentistry of Columbia know at least 48 hours in advance. ***I also understand Aesthetic Family Dentistry of Columbia reserves the right to assess a minimum \$50 fee per hour scheduled for late cancellations and/or missed appointments.***

\_\_\_\_\_ **Responsible Party Signature**

\_\_\_\_\_ **Date**

My signature also applies to the dependents listed at the right:

**Dependent(s)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Acknowledgement of Receipt of Notice of Privacy Practices**

\*You may refuse to sign this Acknowledgement\*

I, \_\_\_\_\_, have received a copy of this office's Notice of Privacy Practices.

(Print Name)

\_\_\_\_\_ **Patient Signature (or Responsible Party)**

\_\_\_\_\_ **Date**