Platteville Dental

960 N. Washington St ~ Platteville, WI 53818
Phone: 608-348-2393

PATIENT REGISTRATION

Patient's Name: _____ Social Security # _____

Address: _____City_____State_____Zip_____

Date of Birth: ____ - ____ - ____ Age: _____ Sex: □ M □ F Marital Status: □Single □Married □Separated □Other

Home Phone: (_____)_____-_____ Cell Phone: (_____)_____-_____

Email Address: _____ May we call you at work? □Yes □No

Employer: _____ Work Phone: (_____)_____-_____ Ext _____

Are you a student? □Yes □No - If yes: □Full-time □Part-time Name of School:_____

Person Responsible for Account (if other than self – spouse or parent/guardian if minor)

Name: _____ Daytime Phone: (_____)_____-_____

Relationship: _____ Date of Birth: ____ - ____ - ____ Social Security # _____

Address: _____City_____State____Zip_____

EMERGENCY CONTACT INFORMATION (relative not living with you)

Name: _____ Daytime Phone: _____

Address: _____

DENTAL INSURANCE INFORMATION (Primary)	**DENTAL INSURANCE INFORMATION (Secondary)**
Insured's Name	Insured's Name
Insured's Employer	Insured's Employer
Insurance Co	Insurance Co
Insurance Co Address	Insurance Co Address
Insurance Co Phone #	Insurance Co Phone #
Insured's SS# DOB - -	Insured's SS# DOB - -
Group# Subscriber/ID #	Group# Subscriber/ID #

FINANCIAL AGREEMENT: Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, and Discover. Outside financing is available upon request and approval. There will be a $25 charge for returned checks. I agree to pay the amount charged by Platteville Dental for all professional treatment. Twenty-eight days after the statement closing date I agree to pay the Platteville Dental a **FINANCE CHARGE** of 18% APR or 1.5% per month, if this is added by the office. I can avoid incurring a finance charge by paying my account balance in full upon receipt of statement. If this account becomes past due, Platteville Dental will take all necessary steps to collect this debt, including referring your account to a collection agency. I agree to pay finance, collection, and/or attorney fees added to any overdue balance.

Patients with Dental Insurance: As a courtesy to you, we will help you process all your insurance claims. This form instructs your insurance company to make payment directly to our office. Please understand that we will provide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid. All charges you incur are your responsibility regardless of your insurance coverage. We ask that you pay the deductible and co-payment at the time we provide service to you.

~We thank you for the opportunity to serve your dental health care needs and welcome any questions concerning treatment or our financial policy.~

CONSENT: I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO PLATTEVILLE DENTAL. I understand that responsibility for payment for Dental Services provided in this office is mine, due and payable at the time services are rendered.

Patient Signature (or guardian if child) _____ **Date** _____

PLATTEVILLE DENTAL HEALTH HISTORY

Patient Name _____ Date of Birth _____

Patient SS#_____ Patient Email _____

Person Responsible for this Account _____ Email _____

How did you first hear about our office?

- ☐ Yellow Pages Phonebook
- ☐ Platteville Journal/Reminder
- ☐ Internet - plattevilledental.com
- ☐ Internet – yellowpages.com
- ☐ Radio Commercial
- ☐ Our Location
- ☐ Insurance Company
- ☐ Platteville Newcomers/Welcome Wagon
- ☐ Friend/Family Member:_____
- ☐ Healthcare Professional:_____
- ☐ Employee of Platteville Dental:_____
- ☐ Other: _____

Dental History

Primary Oral Concern_____ Date of Last Dental Exam _____

What would you like to change about your smile? _____

What is most important to you about your oral health? _____

What do you consider the most important quality in a dentist? _____

DO YOU HAVE OR DO YOU USE ANY OF THE FOLLOWING?

- ☐ Teeth sensitive to cold, heat, sweets or pressure
- ☐ Cigarettes, pipe, cigar or chewing tobacco
- ☐ Bleeding gums or loose teeth
- ☐ Clenching or grinding
- ☐ Swelling or lumps in the mouth
- ☐ Frequent blisters on lips or mouth
- ☐ Pain or sounds in ear while eating
- ☐ Bad breath
- ☐ Unpleasant taste
- ☐ Periodontal treatment
- ☐ Food impaction
- ☐ Orthodontic treatment
- ☐ Mouth breathing
- ☐ Fingernail biting
- ☐ Unfavorable dental experience
- ☐ Texture of toothbrush _____
- ☐ Frequency of brushing __ time(s) / day
- ☐ Mechanical toothbrush
- ☐ Fluoride supplements/vitamins
- ☐ Dental floss ☐ Alcohol mouthwash
- ☐ Alcoholic drinks

Medical History

Physician's name:_____ Date of last Physical exam: _____

Heart Problems, Heart attack, Angina or chest pain, Irregular heartbeat	Yes ☐ No ☐	Lung disease, Emphysema, Bronchitis, chronic cough, shortness of breath	Yes ☐ No ☐
Heart murmur	Yes ☐ No ☐	Neurological problems	Yes ☐ No ☐
High pressure or Low blood pressure	Yes ☐ No ☐	Organ transplant	Yes ☐ No ☐
Rheumatic fever or Rheumatic heart disease	Yes ☐ No ☐	Radiation treatment or chemotherapy	Yes ☐ No ☐
Artificial heart valve or Pacer	Yes ☐ No ☐	Kidney problems	Yes ☐ No ☐
Bleeding Problems/Blood Thinner	Yes ☐ No ☐	Chronic fatigue	Yes ☐ No ☐
Immune system disorders (AIDS, HIV, ARC)	Yes ☐ No ☐	Epilepsy or Seizures	Yes ☐ No ☐
Depression or Anxiety	Yes ☐ No ☐	Liver or Hepatitis illness	Yes ☐ No ☐
Diabetes	Yes ☐ No ☐	Joint replacement	Yes ☐ No ☐
Ulcer or Colitis	Yes ☐ No ☐	Malignancies	Yes ☐ No ☐
Latex sensitive	Yes ☐ No ☐	Nasal or Sinus problems	Yes ☐ No ☐
Thyroid problems	Yes ☐ No ☐	Eye disorder	Yes ☐ No ☐
Substance abuse	Yes ☐ No ☐	Tuberculosis (TB)	Yes ☐ No ☐
Women – Are you pregnant?	Yes ☐ No ☐	Arthritis	Yes ☐ No ☐
Women – Are you nursing?	Yes ☐ No ☐	Lupus	Yes ☐ No ☐
If Pregnant, what month is your due date? _____		Asthma	Yes ☐ No ☐

Describe any current treatment and drugs you are taking: _____

_____

Describe any additional pertinent medical information not listed above: _____

_____

Please list any known drug allergies: _____

APPOINTMENTS: A minimum charge may be made for failed or cancelled appointments without prior notification of 24 hours.

ACKNOWLEDGEMENT: I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor or any staff responsible for any error or omissions that I may have made in the completion of this form.

Signature of patient (or guardian if a minor) _____ Date _____

Platteville Dental

I have read Platteville Dental's Privacy Practices and understand how my health information may be used and disclosed. I also understand that I may request a copy of this Notice of Privacy Practices at any time.

X_____ _____
(Sign) (Date)

I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to my dental claims.

X_____
(Sign)

I hereby authorize payment of the dental benefits otherwise payable to me directly to Platteville Dental, LLC.

X_____
(Sign)