Patient Registration

Today's Date _____

Last Name _____ First Name _____ MI _____ Date of Birth _____

Sex: M or F Soc. Sec# _____ Please Circle: Child Single Married Other Widow

Mailing Address _____ City _____ State ____ Zip Code _____

Email _____ Home Phone (_____)_____ Cell Phone (_____)_____

Emergency Contact _____ Relationship _____ Phone # (_____)_____

Employer _____ Work Phone (_____)_____ Occupation_____

If patient is a minor:

Name of Parent _____ Parent DOB _____ Soc. Sec#_____

Parent Employer _____ Parent Phone (_____)_____

Person Responsible for Account _____ Relationship _____

How did you hear about us?

☐In-home Mailer ☐Social Media ☐Insurance ☐ Practice Website ☐Internet ☐Family/Friend/Coworker

☐Other_____

What is the reason for your visit today?_____

Dental Insurance Information (Primary Carrier)

Insured's Name _____

Insured's Employer _____

Insured's DOB _____

Insurance ID # _____ Group # _____

Insurance Co _____

Insurance Co Address _____

Insurance Phone # _____

Dental Insurance Information (Secondary Coverage)

Insured's Name _____

Insured's Employer _____

Insured's DOB _____

Insurance ID # _____ Group # _____

Insurance Co _____

Insurance Co Address _____

Insurance Phone # _____

Dental History

What would you like to change about your smile?

☐ Color ☐ Bite ☐ Chipped Teeth ☐ Crowding ☐ Smile Makeover ☐ Missing Teeth ☐ Nothing

What is the most important thing to you about your dental visit today? _____

Approximate date of your last cleaning _____ Name of your previous dentist_____

Pharmacy Phone: _____ **Address**: _____

Dental History -Please mark (x) next to any of the following conditions that apply to you

Pain/Discomfort

☐ Sensitivity (hot, cold, sweet)
☐ Pressure/teeth pain
☐ Broken teeth/fillings
☐ Worn teeth
☐ Dry mouth
_____
_____
_____
_____
_____

Function

☐ Grinding/clenching
☐ Headaches/migraine
☐ Jaw joint (TMJ) pain
☐ Jaw joint (TMJ) clicking/popping
☐ Bite cheek or lip frequently
☐ Sores or lumps in mouth
☐ Mouth breathing
☐ Sore muscles (neck, shoulders)
☐ Difficulty opening or closing
☐ Difficulty chewing on either side

Habits

☐ Thumb sucking
☐ Nail-biting
☐ Cheek/lip biting
☐ Chewing on ice/foreign objects

Sleep Pattern or Conditions

☐ Sleep Apnea
☐ Snoring
☐ Daytime Drowsiness

Periodontal

☐ Bleeding/Swollen gums
☐ Loose/shifting teeth
☐ Previous perio/gum disease

Please List Family History of any conditions marked

_____
_____
_____
_____

Medical History -Please mark (x) to indicate if you have or have had any of the following

Cancer

Type _____
Chemotherapy
☐ Radiation Therapy

Cardiovascular

☐ Angina (chest pain)
☐ Artificial Heart Valve
☐ Heart Conditions
☐ Heart Surgery
☐ High Blood Pressure
☐ Low Blood Pressure
☐ Pacemaker
☐ Glaucoma
☐ Ankle/Foot Swelling
☐ Stroke

Endocrinology

☐ Diabetes
☐ Hepatitis A/B/C
☐ Hypoglycemia
☐ Kidney Disease
☐ Liver Disease
☐ Thyroid Disease

Gastrointestinal

☐ Ulcers/Acid Reflux
☐ Gastrointestinal Disease

Hematologic/Lymphatic

☐ Anemia
☐ Blood Disorders
☐ Bruise Easily
☐ Excessive Bleeding

Musculoskeletal

☐ Arthritis
☐ Artificial Joints
☐ Back Pain
☐ Rheumatoid Arthritis

Neurological

☐ Anxiety
☐ Depression
☐ Dizziness
☐ Drug/Alcohol Addiction
☐ Fainting
☐ Seizures/ Epilepsy
☐ Psychiatric Illness
☐ Eating Disorder
☐ Mental Health Disorder

Respiratory

☐ Asthma
☐ Emphysema
☐ Respiratory Problems
☐ Sinus Problems
☐ Sleep Apnea
☐ Tuberculosis

Viral Infections

☐ AIDS
☐ HIV Positive
☐ HPV
☐ Other

Women

☐ Currently Pregnant
☐ Nursing

Medical Allergies

☐ Antibiotics _____
(Penicillin/Amoxicillin/Clindamycin
☐ Opioids _____
(Percocet/Oxycodone /Tylenol 3)
☐ Latex
☐ Local Anesthetics
☐ NSAIDS

Other Allergies

☐ _____

Other

☐ Smoking
Alcohol Frequency: _____
Drug Frequency_____

Physician Name _____ Phone (_____)_____
Have you had a serious illness, operation, or hospitalization in the past 5 years? Y or N If yes, please explain _____

_____

List all medications you are taking, including contraceptives? _____

_____

Have you ever in the past, or are you now currently taking any medications, such as **Bisphophonates for Osteopenia/Osteoporosis** or bone disease? If so,

please list medications _____

The undersigned hereby authorizes Dr. Arroyo to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by Dr. Arroyo to make a thorough diagnosis of patients dental needs. Photographs may be used on webpage anonymously. I authorize Dr. Arroyo to perform medical treatment, medication, and therapy that may be indicted. I also understand the use of anesthetic agents embodies a certain risk. To the best of my knowledge, all of the proceeding answers and information provided are true and correct. If I ever have a change in my health, I will inform the doctor at the next appointment without fail.

_____

Signature of Patient / Legal guardian Print Name Date

Financial Policy

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment. Payment is due at the time the service is provided. Our office accepts cash, personal checks, credit cards and outside patient financing.

Please check if you would like more information about financing options. ☐

Please note: Returned checks will be subject to additional fees. If you fail to pay the office on time and it refers your account(s) to a third party for collection, a collection fee of 25% will be assessed and will be due at the time of the referral to the third party. If your account(s) are referred to an attorney or legal action is taken to cover the account(s) a collection fee of 35% will be assessed and will be due at the time of the referral to an attorney or legal action is taken. Such fee will not be assessed in states where it is prohibited by law.

Do you have Insurance?

- We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company.
- As a courtesy to you we will help you process all your insurance claims. 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 will determine the amount paid. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.
- We ask that you pay the deductible and co-payment, which is the estimated amount, not covered by your insurance company, by cash, check, credit card, or Patient Financing at the time we provide the service to you.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim of being paid. Our office will not enter into a dispute with your insurance company over any claim.

We thank you for the opportunity to serve your dental health care needs and welcome any question you may have concerning your care or our financial policy.

Consent:

I have read, understood and agreed to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge and/or attorney fee will be added to any overdue balance. By signing below, I am authorizing this office to call me at any number I provide including calls to mobile/cellular or similar devices for any lawful purpose. I agree to any fees or charges that I may incur from an incoming call from this office.

_____ _____

Patient signature (Parent if child) *Date*

Acknowledgement of Receipt of Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.
****You may refuse to sign this acknowledgment****

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

_____
Patient Name (Printed)

_____
Signature

_____
Date

Authorization to Release Information

Purpose: This form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself.

I, _____, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

_____	_____
Name (printed)	Relationship
_____	_____
Name (printed)	Relationship
_____	_____
Name (printed)	Relationship