



Patient Registration

Date: _____ Patient Name: _____

Date of Birth: _____ SS # _____ Male _____ Female _____

Marital Status: Single _____ Married _____ Separated _____ Divorced _____ Widowed _____

Home Address: _____ City: _____ State: _____ Zip: _____

Home # _____ Cell # _____ Work # _____

Email Address _____ (For Appointments)

Preferred way to be Contacted: Text _____ Email _____ Phone Call _____

Are you a **College** Student: Full Time _____ Part Time _____ College Name: _____

If patient is a minor, who is legally responsible? _____

Relationship _____ Phone # _____

In case of Emergency, who should we contact? _____

Emergency # _____ Relationship: _____

Were you referred, If Yes who may we thank? _____

How did you hear about us: Internet _____ Flyer _____ Community Event _____ Other _____

Insurance Information:

Do you have Insurance for us to bill for you today: Yes _____ No _____

Subscriber's Name: _____ Subscriber's Employer: _____

Name of Insurance Co: _____ Insurance Phone #: _____

Date of Birth: _____ SS# _____ Subscribers ID # _____

Group # _____ Relationship to Subscriber: _____

Does patient have a **Secondary** insurance? Yes _____ No _____

Subscriber's Name: _____ Subscriber's Employer: _____

Name of Insurance Co: _____ Insurance Phone #: _____

Date of Birth: _____ SS# _____ Subscribers ID # _____

Group # _____ Relationship to Subscriber: _____

**** I hereby authorize payment of the dental and insurance benefits and authorize the release of dental information to my insurance company in order for claims to be processed. I have received and signed the financial policy.**

Patient or Guardian Signature

Date



Medical History

Are you under medical treatment now?

If so, please explain: _____ Treating Physician: _____

Have you ever been hospitalized for any surgery or serious illnesses? Yes ____ No ____ If Yes, what? _____

Have you ever taken any Bisphosphonate drugs such as Fosamax, Actonel, Boniva, or Reclast? Yes ____ No ____

Have you ever taken Fen-Phen (Phentermine)? Yes ____ No ____ Do you need to Pre Med? Yes ____ No ____

MEDICATIONS

Are you currently taking medications? Yes ____ No ____

If yes, what: _____

MEDICAL CONDITIONS

____ Heart Attack/Surgery ____ Hepatitis/Jaundice ____ Arthritis ____ Heart Murmur
____ Kidney Disease ____ Glaucoma ____ Heart Disease/Pacemaker ____ Tobacco User
____ Fainting ____ Chest Pains ____ Thyroid Problems ____ Epilepsy/Convulsions
____ High/Low Blood Pressure ____ Stomach Problems ____ HIV/Aids ____ Rheumatic Fever
____ Leukemia/Anemia/Blood Disorder ____ Stroke ____ Herpes Simplex I or II ____ Drug/Alcohol Abuse
____ Tuberculosis ____ Cancer ____ Radiation/Chemotherapy ____ Asthma/Respiratory
____ Hay Fever ____ Diabetes, Which Type: _____ Other: _____
____ Full/Partial Joint Replacement If yes, When? _____ Which Joint? _____

WOMAN ONLY: Are you Pregnant/Breastfeeding? Yes ____ No ____ Are you taking birth control? Yes ____ No ____

ALLERGIES:

____ Aspirin/Ibuprofen ____ Penicillin ____ Sulfa ____ Codeine ____ Sedative ____ Iodine ____ Latex ____ Local Anesthetic
Other: _____

PATIENT DENTAL HISTORY

When was your last dental visit? _____ Name of previous Dentist? _____

Dental History:

Yes ____ No ____ Are you having pain/discomfort as this time?

Yes ____ No ____ Have you had any problems with your Jaw?

Yes ____ No ____ Do your gums bleed when you brush?

Yes ____ No ____ Do you clench or grind your teeth?

Yes ____ No ____ Are you aware of any lumps in your mouth?

Yes ____ No ____ Earaches, Headaches Neck Pain?

Yes ____ No ____ Teeth or Fillings Breaking?

Yes ____ No ____ Bad Breath or Bad taste?

Yes ____ No ____ Have you ever had a bad experience in a dental office in the past?

Do You have any of the Following?

Yes ____ No ____ Do you wear denture, partial or retainer?

Yes ____ No ____ Do you have braces?

Yes ____ No ____ Do you have a gum disease (Periodontal)?

What would you like to improve?

Whiten ____

Straighten ____

Close Spaces ____

Replace Silver Fillings ____

Repair Chip Teeth ____

Replace Missing Teeth ____

Replace Old Crowns ____

**** I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information may be detrimental to my health.**

Patient /Guardian Signature _____

Date _____



Financial Policy

Thank you for choosing Deluxe Dental as your dental care provider!

Our professional dental team is committed to providing you excellent dental care in a friendly, comfortable setting. The following is a statement of our financial policy, which we request that you read and sign prior to treatment.

Full payment is due at the time of service, unless other arrangement has been made. We accept cash, check, debit card, Visa, MasterCard, Discover, American Express and Carecredit. Interest on balance unpaid beyond 90 days will be applied at the rate of 1.5% monthly (18% annually).

While we do accept assignment of insurance benefits, your portion of each service is due at the time services are rendered. This may be based on an **estimate** of insurance payment, not a guarantee of payment. Your insurance policy is a contract between you, your employer and your insurance company. We are not a party to that contract. We do, however, submit dental claims as a courtesy to our patients and will do our best to assist you in understanding and applying your dental benefits. We cannot guarantee insurance payments or payment amounts. All treatment estimates are provided based upon information from your insurance company and are estimates only. If your insurance company has not paid your account in full within 90 days of billing, we will require the balance to be paid directly by you via cash, check, debit or credit cards.

Treatment plan are created based upon clinical findings during your diagnostic exam and are subject to change based upon clinical need and/or our treatment schedule.

Our policy is to charge for missed appointments or appointments that are not cancelled less than a **24 hour notice** at the rate of **\$25.00** per appointment. Please help us serve you better by keeping scheduled appointments.

Return checks are subject to an additional fee of **\$25.00**.

Unpaid balances are subject to action by a collection agency.

Signature on File

By signing below, I give my permission for Deluxe Dental to release necessary information regarding my treatment to by insurance company(s) and assign dental benefit payments directly to Deluxe Dental.

If you have any further questions regarding our financial policy, please ask a member of our dental team.

I UNDERSTAND AND AGREE TO COMPLY WITH THIS FINANCIAL POLICY.

Print Patient Name: _____ Date: _____

Patient/Guardian Signature: _____ Relationship to Patient: _____



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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

(Please Initial one of the following)

**** I have received a copy of this office's notice of Privacy Practices _____**

**** I have reviewed the notice of Privacy Practices, but declined my copy _____**

Print Patient Name: _____ Date: _____

Patient/Guardian Signature: _____ Relationship to Patient: _____

We attempted to obtain written acknowledgement of receipt of our notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining acknowledgement
- An emergency situation prevented us from obtaining acknowledgment
- Other (please specify): _____

Employee Signature: _____ Date: _____