Patient Registration Information

Date: _____

Name: _____ Patient #: _____

First MI Last

Welcome to our practice!

Thank you for selecting our healthcare team for your dental needs. Please fill out this form in ink. If you have any questions or concerns, please do not hesitate to ask for assistance – we will be happy to help.

Home address _____ City_____ State/Prov _____ Zip/P.C. _____

Date of birth _____ Home Phone _____ Work Phone_____

E-mail _____ Cell Phone _____

Do you prefer to receive calls at? ☐ Work ☐ Home ☐ Either

Are you? ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

You or your parent/guardian's employer_____ Occupation _____

Business address_____ City _____ State/Pr. _____ Zip/P.C._____

Spouse or parent/guardian's name _____ Employer _____ Work phone _____

If student, name of school /college _____ City _____ State/Pr._____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone _____

Patient Registration (cont.)

Name of person responsible for this account _____ Relationship _____

Address _____ State/Pr. _____ Zip/P.C. _____ SSN# _____

Driver's License # _____ Birthdate _____ Financial Institution _____

E-mail _____ Cell Phone _____

Employer _____ Work Phone _____

Is this person currently a patient in our office? ☐ Yes ☐ No

Name of Insured _____

Relationship to patient _____

Birthdate _____ SS/SIN _____ Date employed _____

Employer _____ Work phone _____

Address of employer _____ City _____ State/Pr. _____ Zip _____

Insurance company _____**Group #** _____ **Employer/Cert #** _____

Ins. Co address _____**City** _____ **State/Pr.** _____ **Zip** _____

Deductible amount _____ Used to date? _____ Max annual benefit? _____

Medical History

ALL INFORMATION IS HELD IN STRICT CONFIDENTIALITY

Name	Birthdate	Height	Weight
Physician	Physician Address		Physician Phone
Are you being treated for any medical condition?	If yes, please explain		Date of last physical

Have you ever had:

Yes	No		Yes	No	
		Headaches			Kidney disease
		Seizures or epilepsy			Any other bladder or kidney disorder
		Brain damage			Diabetes
		Head injury			Thyroid disorder
		Glaucoma			More than 10 lbs. weight gain or loss in 6 mos.
		Eye or ear problems			Any other endocrine disorder
		Any other central nervous system disorder			Skin problems (hives, rash, sores)
		Hepatitis			Arthritis
		Jaundice			Inflammatory rheumatism
		Ulcer or colitis			Joint prosthesis
		Any other stomach, intestinal, or liver disorder			Any other skin, joint, or muscular disorder
		Heart disease			Fever blisters
		Hardening of the arteries			Cancer or tumor
		Stroke			X-ray treatment or surgery for tumor or growth
		Rheumatic fever			Venereal disease
		Heart murmur			HIV+
		Congenital defect			Night sweats
		Mitralvalve prolapse			Psychiatric treatment
		Heart prosthesis			Allergic reaction to:
		Abnormal bleeding			Local anesthetic (“Novocain”)
		Hemophilia, anemia, leukemia			Penicillin
		High blood pressure			Other antibiotics:
		Any other heart, blood, or circulatory disorder			Codeine
		Chronic cough			Aspirin
		Tuberculosis			Other drugs:
		Asthma			Other allergies:
		Pneumonia			Do you feel tired in the middle of the day?
		Frequent colds or bronchitis			Do you use more than two pillows to sleep?
		Do you smoke?			Have you been told that you are snoring?
		Any other respiratory disorder			Women:
		Bladder or kidney infection			Are you pregnant? Due date:
		Are you taking: Aredia, Fosamax, Boniva, Actonel, Skelid or Didronel?			Are you nursing?
					Any other condition influencing treatment:

Medical History (cont.)

Hospitalizations: Current medications:

Date	Reason	(prescription & non-prescription)

Dental History:

Yes	No	**For all patients:**
		Is this your first dental visit ever?
		When was your last visit?
		What treatment was performed?
		Have you ever had an unpleasant dental experience?
		If yes, explain:
		How frequently do you floss your teeth?
		Texture of brush used?
		Do your gums bleed when you brush?
		How frequently do you floss your teeth?
		For child patients:
		Has your child ever had an injury to the mouth, teeth, or jaws?
		When?
		How?
		Has your child ever sucked his/her thumb, finger, or pacifier?
		Started:
		Ended:
		Is brushing supervised or assisted? (For children 8 and under)
		For denture patients:
		How long have you worn a denture?
		How long have you had your present denture?
		Do you remove your denture when you sleep?

Financial Policy

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payors and/or other health practitioners.

I authorize and hereby request my insurance to pay directly to the dentist (or the dental group) insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

I realize that failure to keep this account current may result in you being unable to provide additional dental services. In case of default of payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balance.

Our office wants all our patients to be able to comfortably afford dental care. We are proud to offer the following financial policy so that our patients can have the opportunity to decide which payment option best suits their needs;

Insurance: Our office will gladly work with you to help get the maximum benefit available to you. Most dental insurance plans do not cover 100% of your cost of treatment. Because of this, you will be asked to pay your deductible and your co-payment for charges on the day the services are rendered. We will estimate as closely as possible your coverage, but we can make no guarantee of any estimated payment. Because the insurance policy is an agreement between you and the insurance company, the ultimate responsibility for all charges lies with you. If after 60 days the insurance company has not paid on the claim, you will be responsible for the total balance.

Payment options

- Cash or check
- Credit card. We accept Visa, Mastercard, Discover and American Express
- Third Party Financing. Care Credit A health care credit card with a third-party financing that can be applied for through our office. We can assist you apply in the office and will get an answer within minutes. Variable programs available with deferred interest.

Effective immediately for ALL broken appointments without adequate notice (24 hours), a fee will be charged.

We feel strongly that we are best able to serve you and other patients when the time we set aside in our schedule just for YOU is maintained. We value you as a patient and wish to provide you with optimal dental care.

Signature _____ Date _____

Contacts for Information/ Acknowledgement of receipt of notice of privacy policies

I, _____, Date of Birth _____, request that the following be allowed for the disclosure of my Protected Health Information (PHI). Protected Health Information would include your name, diagnosis, test results, dates of services.

- Sensitive Protected health Information (HIV- related information)
- You may disclose information to my family members and/or non-family members listed below:

Name **Phone Number** **Relationship**

_____

_____

_____

_____

- You may leave Protected Health Information on my answering machine/voice mail
  Phone Number: _____
- You may leave a text message, phone number: _____
- You may email (unencrypted) for dental appointments. Email: _____
- You may fax for dental information. Fax number: _____
- Other: _____

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

Print Name: _____

Signature: _____

(patient's signature or guardian if minor)

Date: _____

FOR OFFICE USE ONLY

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 prohibit obtaining the acknowledgment
- An emergency prevented us from obtaining the acknowledgment
- Other (Please specify): _____

Guarantee of treatment/Failed appointment

Your scheduled appointment is reserved specifically for you. It is extremely important that all patients honor their reserved dental appointment. Failure to do so deprives other patients from receiving dental care in a timely fashion. We reserve the right to charge for appointments that are cancelled or broken without 48hrs notice. Any broken appointment charges will need to be taken care before you will be able to reschedule for another appointment.
WE understand that emergencies arise unexpectedly, and we will carefully assess each instance before applying any broken appointment fees. The charge associated with our policy is to be paid within 30 (thirty) days to prevent collection procedures. Multiple cancellations and broken appointments may result in dismissal from Global Smiles Dental.

If any restoration completed within the past year needs repaired for any reason, we will take care of it at NO charge. However, if you have not honored your hygiene appointments (every 3,4 or 6 month) intervals, we will not be able to honor this policy due to our inability to monitor and address changes in your oral health. It is very important to keep all of your hygiene appointments as that will allow us to closely monitor and address if needed any areas of concern,

Name_____

Signature_____

Date_____

PATIENT AUTHORIZATION AND RELEASE FORM

I consent and agree that the photograph(s), video footage, or medical image(s) made of me by **Gurusharan Singh, DDS**, may be distributed to and used by **Global Smiles Dental** for the purpose of public information or any other purpose Global Smiles Dental deems appropriate to inform the medical profession or the general public about the field of dentistry.

I grant this consent as a voluntary contribution. I understand that such photograph(s), video footage, or medical image(s) shall become property of **Global Smiles Dental** and may be shown, published, printed, broadcast or otherwise disseminated in any medium. I release and discharge **Dr. Gurusharan Singh, Global Smiles Dental** and all parties acting under their licenses and authorities from all rights that I may have in the photograph(s), video footage, or medical image(s), including any claim for payment in connection with their distribution or publication.

I understand that, to the extent permitted by law, I have the right to inspect and copy the photograph(s), video footage, or medical image(s), that I have authorized to be disclosed.

By signing this form, I certify that I have read the above authorization and release and fully understand its terms.

Full Name: _____

Address: _____

Signature: _____

Date: _____