PATIENT REGISTRATION FORM

Patient Information

Patient's Name: _____
Last **First** **Middle Initial**

Preferred Name: _____

Address: _____
Street **City** **State** **Zip Code**

Email Address: _____ **SSN:** _____ - ____ - _____ **Date of Birth:** _____/ _____ / ____

Sex: ☐ **M** ☐ **F** **Home No:** _____ **Cell No:** _____**Alt. No:**_____

Marital Status: ☐**Married** ☐**Single** ☐**Divorced** ☐**Separated** ☐**Widowed**

Responsible Party *(if someone other than the patient)*

Parent/Guardian Name: _____
Last **First** **Middle Initial**

Relationship to Patient: _____

SSN: _____ - _____- _____ **Date of Birth:** _____ / ____ / _____ **Drivers Lic:** _____

Primary Insurance Information

Name of Insured (primary policy holder): _____

Relationship to insured: ☐ **Self** ☐**Spouse** ☐**Child** ☐**Other**

Insured Soc Sec #: _____ **Insured Birth Date:** _____

Employer:_____

Address: _____
City,State,Zip: _____
Ins Co: _____
Address: _____
City,State,Zip: _____

Secondary Insurance Information (if any)

Name of Insured (primary policy holder): _____

Relationship to insured: ☐ **Self** ☐**Spouse** ☐**Child** ☐**Other**

Insured Soc Sec #: _____ **Insured Birth Date:** _____

Employer:_____

Address: _____
City,State,Zip: _____
Ins Co: _____
Address: _____
City,State,Zip: _____

DENTAL AND MEDICAL HISTORY FORM

Reason for today's dental visit: _____

Date of last dental visit: _____

Are you nervous about dental treatment? ☐ Yes ☐ No

Do your gums bleed, feel tender or irritated? ☐ Yes ☐ No

Are you unhappy with appearance of your teeth? ☐ Yes ☐ No

Are your teeth sensitive? ☐ Yes ☐ No

If yes, to what? ☐ Sweets ☐ Hot ☐ Cold ☐ Pressure

Are you now seeing a physician? ☐ Yes ☐ No

The name & telephone number of your physician(s)_____

If so, what is the condition being treated? _____

Are you taking any medications? ☐ Yes ☐ No If yes, please _____

Have you or are you currently taking Aspirin? ☐ Yes ☐ No

Have you or are you currently taking oral Bisphosphates? ☐Actonel ☐ Boniva ☐ Fosamax ☐ Other:_____

Have you had any joint replacements? ☐ Yes ☐ No If yes, when? _____

If female, are you or do you suspect to be pregnant? ☐ Yes ☐ No Months: _____

Is there anything else we should know about your health that was not covered on this form? If yes, Please explain:_____

Please mark any of the following which you have had or have at present:

- ☐ AIDS/HIV Positive
- ☐ Alzheimer's Disease
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Blood Disease/Transfusion
- ☐ Breathing Problems
- ☐ Chemo: (Cancer, leukemia)
- ☐ Chest Pains
- ☐ Cold Sore/Fever Blister
- ☐ Congenital Heart Disease
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Emphysema
- ☐ Epilepsy/Seizures
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Fainting spells / Dizziness
- ☐ Glaucoma
- ☐ Heart Attack/ Failure
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Heart Disease
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hypoglycemia
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Pain in Jaw/Joints
- ☐ Parathyroid Disease
- ☐ Psychiatric Care
- ☐ Cortisone Medicine
- ☐ Frequent Headache
- ☐ Radiation Treatment
- ☐ Renal Dialysis
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Stroke
- ☐ Swelling of the limbs
- ☐ Thyroid Disease
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Yellow Jaundice

Please mark any of the following medical allergies:

☐ NONE ☐ Local Anesthetics ☐ Penicillin ☐ Codeine ☐ Iodine ☐ Sulfa ☐ Latex ☐ Metal ☐ Acrylic ☐ Other: _____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if any medicines change, I will inform my dentist at the next appointment.

_____

Signature of Patient/Parent/Guardian

Medical History Update:

_____	_____	_____
Dr. Date	Dr. Date	Dr. Date

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL/PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

SUMMARY:

By law we are required to provide you with our Notice of Privacy Practices (NPP). This notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient you have the following rights:

1. **The right to inspect and copy your information;**
2. **The right to request corrections to your information;**
3. **The right to request that your information be restricted;**
4. **The right to request confidential communications;5. The right to report of disclosures of your information; and**
6. **The right to a paper copy of this Notice.**

We want to assure you that your medical/protected health information is secure with us. This Notice of Privacy Practice contains information about how we will insure that your information remains private.

Please list all telephone numbers where we may contact you:

1._____2. _____3. _____

4. _____5. _____6. _____

PLEASE LIST THE NAMES OF ALL PEOPLE (e.g. SPOUSE, PARENTS, GRANDPARENTS, ETC...) YOU AUTHORIZE US TO RELEASE YOUR HEALTH INFORMATION TO, INCLUDING COPIES OF YOUR RECORDS IF NEEDED:

Name _____Relationship _____

Name _____Relationship _____

Name _____Relationship _____

Name _____Relationship _____

Acknowledgement of Notice of Privacy Practice

I hereby acknowledge that I have reviewed this practice's Notice of Privacy Practice. I further understand that the practice will offer me updated to this Notice of Privacy Practice. Should it be amended, modified or changed in any way I will receive a copy.

_____

Printed Name of Patient

_____

Signature of Patient/Parent/Guardian

FOR OFFICE USE ONLY

❑Patient refused to sign

❑Patient was unable to sign because: _____

Date: _____Signature: _____

OFFICE FINANCIAL POLICIES AND

FEDERAL TRUTH-IN-LENDING STATEMENT

Financial arrangements must be made and financial responsibility must be determined for each patient beginning dental treatment or services.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are rendered.

Patients who carry dental insurance understand that all dental services provided are charged directly to the patient and that he or she is personally responsible for payment of all dental service. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by the insurance company.

You will receive a monthly statement on any unpaid balance. A service charge of 1.5% per month (18% per annum) with a minimum charge of $.50 per month, on the unpaid balance will be charged on all accounts exceeding 60 days from the date of service, unless previously written financial arrangements are satisfied.

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

In consideration for the professional services rendered by this dental office to me, or at my request to my minor child, I agree to pay the fees charged at the time the services are rendered, or within five (5) days of billing if credit shall be extended. Payment can be made with cash, personal check, Mastercard, Visa, American Express or Discover Card. In the case of default of payment of the fees charged I agree to pay the remaining balance plus reasonable attorney fees, court costs and a collection agency commission of 40% of the delinquent balance if the account is assigned to a collection agency or attorney. I authorize the release of financially identifiable information concerning my account, including charges billed, payments made, and interest charges assessed, etc. to the dentist's collection agency or collection attorney should procedures as described become necessary.

I grant permission to this dental office to telephone me at home or at my workplace to discuss matters related to dental services provided or fees charged and/or payments made for such services. I also agree to allow this office to leave messages concerning appointments or other information on my answering machine or with a family member.

This agreement supersedes all prior agreements signed, including any and all mediation, mediation/ arbitration or financial agreements. Any such agreements previously signed are null and void.

I authorize this dental office to release financially identifiable information and treatment descriptions and information, either electronically, by facsimile or in paper form to my insurance carrier or any related entities that require such information to be submitted.

I acknowledge that I have been offered a copy of this office's Privacy Policies. I agree to disclose to the dentist names of any individuals with whom I authorize the dentist to discuss my dental care.

I certify that I have read this form and I hereby agree to abide by the conditions outlined herein.

_____ _____ _____

Signature of Patient, Parent or Guardian Date Relationship to Patient

PRACTICE POLICIES

Our goal is to provide quality dental care in a timely manner. In order to do so we have a cancelation and no-show policy. The policy enables us to better utilize available appointments for our patients in need of dental care.

CANCELLATION OF AN APPOINTMENT

In order to be respectful of others patients' needs, please be courteous and call our office promptly if you are unable to attend an appointment. This time will be given to someone who is in urgent need of treatment. We ask that you contact us 48 hours in advance. Cancellations will be documented and can lead to charges if reoccurring.

NO SHOW POLICY

A "no show" is an appointment that was not cancelled in advance. No shows inconvenience other patients who need dental care. A no show for a scheduled appointment will result in a fee of $50 for every hour scheduled.

LATE ARRIVAL

In an effort to serve our patients in a timely manner, we ask that you are on time for your scheduled appointment. In the event you are running late, please call the office. If you are more than 15 minutes late to your scheduled appointment, you may be asked to reschedule.

CELL PHONE POLICY

As a courtesy to other patients and in an effort to maintain our schedule, we request that cell phones be put away while the doctor, hygienist, or assistant is in the room with you. We also ask that no photos or videos be taken without permission from the doctors or staff.

TREATMENT DOWN PAYMENT

We require a down payment of $50 to book a treatment appointment on major cases. The down payment will go toward your out of pocket copay but will be non-refundable if you cancel without 48hours notice or no show your appointment.

X-RAYS

We require diagnostic x-rays every six months or when a doctor deems necessary. It is your responsibility if your insurance does not cover the cost. *We will not be able to see patients who refuse these services for an appointment of any kind.*

I have read and understand the "Practice Policies"

_____

Patient's Name (Printed)

_____

Patient's Name (Signature)

_____

Date

Infinite Smiles
COSMETIC DENTISTRY

Who can we thank for your visit with us today?

- □ Drive/Walk By
- □ Insurance Company
- □ Transfer from another dental office
- □ Patient Referral: _____
- □ Online Search
- □ Mailer
- □ Staff
- □ Other: _____

Are there any particular issues or services you would like to discuss:

- □ Toothache/Pain
- □ Removal of Wisdom Teeth
- □ Bridge/Partials/Dentures
- □ Teeth Whitening
- □ Gum Bleeding/Pain
- □ Chipped or cracked teeth
- □ Invisalign
- □ Other: _____

AUTHORIZATION, RELEASE AND AGREEMENT

I hereby give my permission to Martha Day, DDS PLLC and all of its dental office subsidiaries and/or affiliates to photograph and/or videotape and use my image, likeness or voice for the purpose of promoting. I waive any right that I may have to inspect or approve the photography and/or videotape or sound clips or any associated use of the aforementioned in any materials. Any such use shall be without payment to me of any kind.

I hereby release Martha Day DDS PLLC and its parent corporation, investors, officers, directors, affiliates and subsidiaries, franchisees and related agencies from any liability relating to the use of the image(s), including, but not limited to, any blurring, alteration or use of the photograph and/or videotape or materials in any publications.

I understand and agree that this Authorization, Release and Agreement shall be effective forever form the date below.

_____

Signature

_____

Printed Name

_____

Address

_____

Telephone Number

_____

Date Signed