THORNTON VALLEY DENTAL REGISTRATION FORM

Today's Date:

PATIENT INFORMATION

Patient's last name: First Name:	Middle: [Initial]	Married: [ ] Yes [ ]No
Address: Apt: City: State: Zip:		Birth date:
Social Security no:	Home phone no:	Cell phone no:
Email:	How did you hear about us? (If someone referred you please write their name so we can thank them	

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Patients relationship to subscriber: [ ]- Self [ ]-Spouse [ ]- Child

Insurance Company: Insurance phone number:				
Subscriber's name:	Subscriber's S.S. no:	Birth date:	Group no:	Policy no:

INSURANCE INFORMATION

Name of secondary insurance (if applicable):	Subscriber's name:	Group no:	Policy no:

Patients relationship to subscriber: [ ]- Self [ ]-Spouse [ ]- Child

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone no:	Cell phone no:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Thornton Valley Dental or insurance company to release any information required to process my claims. I understand that if I begin treatment that involves lab work, I will be responsible for the fee at that time. Treatment plans may change, and I will be responsible for the work done. Every effort will be made to help me with my insurance, but if they do not pay as expected, I will still be responsible. If sent to collections, I agree to pay all related fees and court costs. I agree to pay finance charges of 1.5% per month (18% APR) on any balance 90 days past due. I will pay a fee for appointments broken without 24 hours notice.

Patient/Guardian signature

Date

THORNTON VALLEY DENTAL

REGISTRATION FORM PART TWO

NOTICE OF PRIVACY POLICIES

I have had full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities and healthcare operations. I also understand that I have the right to revoke permission.

_____

Patient/Guardian signature Date

MEDICAL HISTORY

Name: DOB:

Name of Medical Doctor:	City/State:	Date of Last appt:
Are you in good health?(Check one) [ ] Yes [ ] No	Any change in your health in the past year?	Are you currently pregnant? [ ] Yes [ ]No
Any serious operations or hospitalizations?		
List all the medications or drugs you are now taking:	List all the medications or drugs you are allergic to:	

MEDICAL CONDITIONS

List any medical conditions you may have including: [ ]Asthma [ ]Arthritis [ ]Bleeding Problems [ ]Cancer [ ]Diabetes [ ] Heart murmur [ ]Heart Trouble [ ]High Blood Pressure [ ]Joint Replacement [ ]Kidney Disease [ ]Liver Disease [ ]Lung Disease [ ]Mouth sores [ ]Neurological disorders [ ]Pregnancy [ ]Psychiatric treatment [ ]Radiation [ ]Sinus trouble [ ]Stroke [ ]Ulcers [ ]History of rheumatic fever [ ]Bisphosphonate use [ ]NONE

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Tobacco Use? If so, what kind and how much?_____

Unusual reaction to dental injections?_____

NEW PATIENTS

Reason for today's visit?	Are you in pain?

Do you have a panoramic x-ray or full mouth x-rays that are less than 5 years old?

Do you have BiteWing x-rays that are less than 1 year old? [ ] Y [ ]N

Name of former Dentist? City/State:

Date of last cleaning and exam?

Any additional information you would like us to know:

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Patient/ Guardian Signature Date