ARLINGTON DENTAL CLINIC

PATIENT REGISTRATION

PATIENT PERSONAL INFORMATION

Title_____ Nickname_____ Birth Date_____ Marital Status_____ Sex_____

Last Name_____ First_____ Middle_____

Address_____ City_____ State_____ Zip_____

Home #_____ Cell #_____ Drive Lic #_____

Email Address_____ SSN_____

Emergency Contact_____ Emergency Contact Phone #_____

Health Care Guardian Name_____ Health Care Guardian Phone #_____

Student ____Y ____N School Name _____ Employer _____

Referral Type (How did you hear about us?)_____

PERSON RESPONSIBLE/GUARANTOR FOR PAYING BILLS *(If self, skip to next section)*

Title_____ Nickname_____ Birth Date_____ Marital Status_____ Sex_____

Last Name_____ First_____ Middle_____

Address_____ City_____ State_____ Zip_____

Home #_____ Cell #_____ Drive Lic #_____

Email Address_____ SSN_____

DO YOU HAVE PRIMARY DENTAL INSURANCE ____Y ____N

Group No/Name_____

Insurance Name_____

Phone #_____

Employer Name_____

Subscriber Last, First_____

Subscriber ID_____ Birth Date_____

Subscriber SSN_____ *(*Required by some Insurances)*

Subscriber Address_____

City_____ State_____ Zip_____

Relationship to Patient_____

DO YOU HAVE SECONDARY DENTAL INSURANCE ____Y ____N

Group No/Name_____

Insurance Name_____

Phone #_____

Employer Name_____

Subscriber Last, First_____

Subscriber ID_____ Birth Date_____

Subscriber SSN_____ *(*Required by some Insurances)*

Subscriber Address_____

City_____ State_____ Zip_____

Relationship to Patient_____

CONSENT

- *I hereby authorize staff to take X-rays, photographs and any other diagnostic aids deemed appropriate by to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I consent to the use of appropriate medication and therapy as deemed necessary.*
- *I hereby authorize payment of the dental benefits, otherwise payable to me, directly to the office. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan.*
- *By signing below, I certify that I read and write English and I have read, fully understand, and agree to the above office policies.*

Signature of Patient or Responsible Party _____ ***Date*** _____

PATIENT MEDICAL INFORMATION

ARE YOU ALLERGIC TO?					
Aspirin	◯ No ◯ Yes	Barbiturates / Sleeping Pills	◯ No ◯ Yes	Codeine	◯ No ◯ Yes
Erythromycin	◯ No ◯ Yes	Iodine	◯ No ◯ Yes	Latex Rubber	◯ No ◯ Yes
Local Anesthetics	◯ No ◯ Yes	Acrylic	◯ No ◯ Yes	Metals	◯ No ◯ Yes
No Epinephrine	◯ No ◯ Yes	Penicillin	◯ No ◯ Yes	Sulfa Drugs	◯ No ◯ Yes
Other Narcotics	◯ No ◯ Yes				
WOMEN ONLY: ARE YOU?					
Pregnant / Trying to	◯ No ◯ Yes	Taking oral contraceptives	◯ No ◯ Yes	Nursing	◯ No ◯ Yes
DO YOU HAVE, OR HAD ANY?					
AIDS/HIV Infection	◯ No ◯ Yes	Alzheimer's Disease	◯ No ◯ Yes	Anaphylaxis	◯ No ◯ Yes
Anemia	◯ No ◯ Yes	Angina	◯ No ◯ Yes	Anorexia	◯ No ◯ Yes
Arteriosclerosis	◯ No ◯ Yes	Arthritis / Gout	◯ No ◯ Yes	Artificial Heart Valve	◯ No ◯ Yes
Artificial Joint	◯ No ◯ Yes	Asthma	◯ No ◯ Yes	Autoimmune Disease	◯ No ◯ Yes
Bladder Trouble	◯ No ◯ Yes	Blood Clotting Problems	◯ No ◯ Yes	Blood Disease	◯ No ◯ Yes
Blood Transfusion	◯ No ◯ Yes	Breathing Problem	◯ No ◯ Yes	Bruise Easily	◯ No ◯ Yes
Bulimia	◯ No ◯ Yes	Bronchitis	◯ No ◯ Yes	Cancer	◯ No ◯ Yes
Cardiac Pacemaker	◯ No ◯ Yes	Cardiovascular Disease	◯ No ◯ Yes	Chemotherapy	◯ No ◯ Yes
Chest Pains	◯ No ◯ Yes	Cold Sores / Fever Blisters	◯ No ◯ Yes	Color Blindness	◯ No ◯ Yes
Congenital Heart Defect	◯ No ◯ Yes	Contact Lenses	◯ No ◯ Yes	Convulsions	◯ No ◯ Yes
Congestive Heart Failure	◯ No ◯ Yes	Cortisone Medicine	◯ No ◯ Yes	Damaged Heart Valve	◯ No ◯ Yes
Diabetes	◯ No ◯ Yes	Drug Addiction	◯ No ◯ Yes	Easily Winded	◯ No ◯ Yes
Emphysema	◯ No ◯ Yes	Environmental Allergies	◯ No ◯ Yes	Epilepsy / Seizures	◯ No ◯ Yes
Excessive Bleeding	◯ No ◯ Yes	Excessive Thirst	◯ No ◯ Yes	Fainting Spells / Dizziness	◯ No ◯ Yes
Frequent Cough	◯ No ◯ Yes	Frequent Diarrhea	◯ No ◯ Yes	Frequent Headaches	◯ No ◯ Yes
Frequently Dry Mouth / Sjogren	◯ No ◯ Yes	Gag Reflex	◯ No ◯ Yes	Gall Bladder Trouble	◯ No ◯ Yes
Genital Herpes	◯ No ◯ Yes	Glaucoma	◯ No ◯ Yes	Hay Fever	◯ No ◯ Yes
Heart Attack / Failure	◯ No ◯ Yes	Heart Disease / Trouble	◯ No ◯ Yes	Heart Murmur	◯ No ◯ Yes
Heart Pacemaker	◯ No ◯ Yes	Hemophilia	◯ No ◯ Yes	Hepatitis A	◯ No ◯ Yes
Hepatitis B or C	◯ No ◯ Yes	Herpes	◯ No ◯ Yes	High Blood Pressure	◯ No ◯ Yes
High Cholesterol	◯ No ◯ Yes	Hives / Rash	◯ No ◯ Yes	Hypoglycemia	◯ No ◯ Yes
Irregular Heartbeat	◯ No ◯ Yes	Kidney Problems	◯ No ◯ Yes	Leukemia	◯ No ◯ Yes
Liver Disease	◯ No ◯ Yes	Low Blood Pressure	◯ No ◯ Yes	Lung Disease	◯ No ◯ Yes
Lupus	◯ No ◯ Yes	Mental Health Problems	◯ No ◯ Yes	Mitral Valve Prolapse	◯ No ◯ Yes
Osteoporosis	◯ No ◯ Yes	Pain in Jaw Joints	◯ No ◯ Yes	Parathyroid Disease	◯ No ◯ Yes
Persistent Diarrhea	◯ No ◯ Yes	Psychiatric Care	◯ No ◯ Yes	Premedicate	◯ No ◯ Yes
Radiation Treatments	◯ No ◯ Yes	Recent Weight Loss	◯ No ◯ Yes	Renal Dialysis	◯ No ◯ Yes
Rheumatic Fever	◯ No ◯ Yes	Rheumatic Heart Disease	◯ No ◯ Yes	Rheumatism	◯ No ◯ Yes
Scarlet Fever	◯ No ◯ Yes	Sexually Transmitted Disease	◯ No ◯ Yes	Shingles	◯ No ◯ Yes
Skin Rash	◯ No ◯ Yes	Sickle Cell Disease	◯ No ◯ Yes	Sinus Trouble	◯ No ◯ Yes
Spina Bifida	◯ No ◯ Yes	Stomach / Intestinal Disease	◯ No ◯ Yes	Stroke	◯ No ◯ Yes
Swelling of Limbs	◯ No ◯ Yes	Thyroid Disease	◯ No ◯ Yes	Tonsillitis	◯ No ◯ Yes
Tuberculosis	◯ No ◯ Yes	Tumors / Growths	◯ No ◯ Yes	Ulcers	◯ No ◯ Yes
Urinate Frequently	◯ No ◯ Yes	Venereal Disease	◯ No ◯ Yes	Yellow Jaundice	◯ No ◯ Yes
Anything not mentioned above	◯ No ◯ Yes				

ADDITIONAL COMMENTS _____

_____

_____

_____

Signature of Patient or Responsible Party _____ ***Date*** _____

ARLINGTON DENTAL CLINIC

DENTAL QUESTIONNAIRE

Reason for this visit	
Date of your last exam	
Date of your last cleaning	
Date of your last full series x-rays	
Date of last cavity detection	
Name of previous Dentist	
Phone #	
How often do you brush your teeth?	
How often do you floss your teeth?	
Is your drinking water fluoridated?	◯ No ◯ Yes
Do your gums bleed while brushing or flossing?	◯ No ◯ Yes
Are your teeth sensitive to hot, cold or sweets?	◯ No ◯ Yes
Do you get frequent fever blisters, mouth ulcers, or sores on your lips or in your mouth?	◯ No ◯ Yes
Have you ever had burning of the tongue or cracking of the corners of your mouth?	◯ No ◯ Yes
Do you notice popping, clicking or soreness of the jaws or points just in front of the ears?	◯ No ◯ Yes
Do you clench or grind your teeth?	◯ No ◯ Yes
Have you ever had orthodontic treatment?	◯ No ◯ Yes
If yes, date of placement	
Do you wear dentures or partials?	◯ No ◯ Yes
If yes, date of placement of dentures?	
Are you happy with your dentures?	◯ No ◯ Yes
Are you having any specific problems with your teeth, gums, or mouth at this time?	◯ No ◯ Yes
Are you happy with your smile?	◯ No ◯ Yes
Do you have problems with teeth/fillings breaking?	◯ No ◯ Yes
Have you ever had any prolonged bleeding following extractions?	◯ No ◯ Yes
Do you have, or have you ever been told, that you have Pyorrhea (Periodontal Disease)?	◯ No ◯ Yes
Do you have difficulty in opening your mouth widely?	◯ No ◯ Yes
Do you have an unpleasant taste or odor in your teeth/mouth?	◯ No ◯ Yes
Does food catch between your teeth?	◯ No ◯ Yes

ADDITIONAL COMMENTS _____

ARLINGTON DENTAL CLINIC

MEDICAL QUESTIONNAIRE

Are you currently under care of a Physician?	◯ No ◯ Yes
If Yes, please explain	_____
Name of your Primary Care Physician(PCP)?	_____
Phone	_____
Have you had any serious illness, operation or been hospitalized within the past 5 years?	◯ No ◯ Yes
If Yes, what illness or problem?	_____
Have you ever had a serious head or neck injury?	◯ No ◯ Yes
If yes, please explain	_____
Are you currently taking any medication, pills, or drugs?	◯ No ◯ Yes
If Yes, what?	_____
Have you taken bisphosphonates (Fosamax, Boniva, Zometa, Actonel, Didronel, Aredia, Skelid, Reclast)	◯ No ◯ Yes
Have you ever taken the diet control drug Fen-Phen?	◯ No ◯ Yes
Do you use alcoholic beverages?	◯ No ◯ Yes
Do you chew / smoke tobacco in any form?	◯ No ◯ Yes
Do you use controlled substances?	◯ No ◯ Yes

ADDITIONAL COMMENTS _____

_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient or Responsible Party _____ ***Date*** _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

Please Print Name

Signature of Patient or Responsible Party _____ ***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 prohibited obtaining the acknowledgement
◯ An emergency situation prevented us from obtaining acknowledgement
◯ Other (Please specify)_____

ARLINGTON DENTAL CLINIC

OFFICE POLICIES

Thank you for choosing our office as your dental health care provider. We believe that all patients deserve the very best dental care we can provide. Below are the list of our Office Policies which we require that you read and sign prior to any treatment. All patients must complete our Patient Registration forms before seeing the dentist.

New Patient Policy

All new patients will be scheduled for a dental consultation with the dentist for their first visit. This consultation includes the oral exam, x-rays, and a treatment plan. Before the comprehensive oral exam of your teeth, gums, and mouth, the doctor will go over your medical history, dental history, and any oral health worries. Radiographs (x-rays) and intra-oral pictures will be taken during this appointment. The doctor will not perform the oral exam without radiographs as they allow the doctor to see underneath the gums to detect bone loss, decay, and calculus build-up. This will help the doctor make the proper diagnosis. Recent radiographs can be sent to us from another dental office; however, they must be of diagnostic quality and no more than six months old. Please be aware that a dental CLEANING is not guaranteed the same day as your consultation. We have to determine your dental needs and concerns first, then tailor your hygiene treatment to you. The consultation concludes with a treatment plan that is tailored to your needs and designed to prevent small issues from getting bigger and more expensive.

Financial Policy

Regarding Insurance:

Your complete insurance information must be presented at the time services are provided. Insurance claims cannot be backdated. Pre-authorization from your insurance may be required before any work can be done to protect you from unexpected payment responsibilities. Your Insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. Dental insurance is not meant to be a "pay-all" it is only meant to be an aid. Office will file claim on your behalf a maximum of two times as a courtesy. After which patient will be billed and may request a copy of the claim to submit manually. If you have any questions regarding your coverage, you should contact your insurance carrier. It's your responsibility to know your coverage. We make every effort to provide for you an accurate estimate with the information you and your insurance provides us. Please be aware that your patient responsibility estimates are only an approximation and may change as we acquire more information from your insurance. Insurance co-pays and deductibles must be paid at the time of service. If for any reason your insurance does not pay its expected portion for a completed procedure, that balance will become the responsibility of the patient a statement of balance due will be generated and sent to you. Please be aware that the process of insurance billing and auditing of patient account may occur sometime after you date of service. We always strive to ensure all insurance payment information and patient responsibilities are correct. All invoices are due and payable within 30 days of service. Interest will be charged on past due invoices at the rate of 1.5% per month (18% per annum). In the event it becomes necessary to turn your account(s) over to a collection agency or use an attorney, the responsible party promises to pay, in addition to the amount due, all costs of collection, court costs, and reasonable attorney fees.

Regarding Payment:

We accept the following forms of payment: Cash, Check, Money Order, Visa, Mastercard, Discover, American Express, and Care Credit. All returned checks will be subject to a $25.00 returned check fee. This fee covers the processing fees our office incurs. Payment in full is due at the time services are rendered unless an agreement has been reached in writing between the office and the patient. For major work (dentures, partials, crown, etc.), a 50% deposit is required to start the procedure and the remaining balance will be due upon delivery.

Refund Policy:

You may discontinue treatment and request a refund at any time. We will refund any amount paid for treatment that you did not receive. Please be aware that after the treatment is completed, it is non- refundable. This includes, but is not limited to initial services such as exams, radiographs, cleanings, etc. All refunds will be processed back to the original form of payment, except cash payments which will be refunded by check. All refund requests, cash or credit card may take up to 15 business days to process. Any refund of payment originated through third party lenders must be refunded to the original account. Please contact the third-party lender for more information regarding their refund policy as processing of refunds may not be reflected on an account for up to 2 billing cycles. Refunds for prosthetics (Dentures, partial dentures, crowns, etc.) and appliances (night guards, clear aligners, retainers, space maintainers, etc.) are available however, all fees are built into the prices of the prosthetics or appliance. These fees include the material fees, the lab fees, the labor fees, and the shipping fees. All lab fees are included in the price of any prosthetic, however, if you choose to discontinue the treatment, the lab fee will still be charged to your account.

ARLINGTON DENTAL CLINIC

No-Show Policy

Our office defines a “No-show” appointment as any scheduled appointment in which the patient either:

- Does not arrive to the appointment
- Cancels with less than 24 hours' notice
- Arrives more than 10 minutes late and is consequently unable to be seen

Impact of a “No-Show” Appointment:

“No-show” appointments have a significant negative impact on our practice and the care we provide to our patients. When a patient “no-show” a scheduled appointment it:

- Potentially jeopardizes the health of the “no-showing” patient
- Is unfair (and frustrating) to other patients that would have taken the appointment slot
- Disrespects not only the provider's time, but also the time of the entire clinic staff

How to Avoid Getting a “No-Show”:

Appointment Confirmation

We will attempt to contact you one business days and two hours before your scheduled appointment to confirm your visit. If we are unable to speak with you and must leave a message, you will need to contact office before the appointment, otherwise the appointment will be canceled and marked as a “no-show”.

Always Arrive 5-10 Minutes Early

When you schedule an office visit with us, we expect you to arrive at our practice 5-10 minutes prior to your scheduled visit. This allows time for you and our staff to address any insurance or billing questions and/or to complete any necessary paperwork before the scheduled visit.

Give 24 Hours' Notice if You Need to Cancel

When you need to cancel or rebook a scheduled visit, we expect you to contact our office no later than 24 hours before the scheduled visit. This allows us a reasonable amount of time to determine the most appropriate way to reschedule your care as well as giving us the opportunity to rebook the now vacant appointment slot with another patient. If it is less than 24 hours before your appointment and something comes up, please give us the courtesy of a phone call.

Consequences of “No-Show” Appointments

- If you miss 3 or more appointments within 90 days, you may be dismissed from the clinic.
- Patient dismissal is at the discretion of your dental provider and the practice manager.
- If you are dismissed from the clinic, your remaining scheduled appointments will be cancelled.
- Only emergency dental treatment will be offered within the first 30 days of dismissal.
- Reapplication to the clinic after a six-month period after initial dismissal letter will be considered by your dental provider and the practice manager.

By signing below, **I certify that I read and write English and I have read, fully understand, and agree to the above office policies.**

Signature of Patient or Responsible Party _____ ***Date*** _____