Patient Registration

Patient First Name:_____ Last Name: _____ Middle Initial: _____

Nickname: _____ If Minor: Parent/ Guardian Name(s): _____

PATIENT INFORMATION:

Cell Phone:(____)_____ Home Phone: (____)_____ Email: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Birth Date: _____ Sex: ☐Male ☐Female ☐Other:_____

Social Security #:_____ Driver's License #:_____

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

Employment Status: ☐Fulltime ☐Part Time ☐Retired ☐Unemployed ☐Minor ☐Student

Employer:_____ Present Position:_____

Preferred Pharmacy:_____ Address:_____ Phone #:(___)_____

Emergency Contact Name:_____ **Relationship:**_____ **Phone #:(___)**_____

Referred By:_____

RESPONSIBLE PARTY: (Parent/Guardian responsible for account, if applicable)

☐ **Check here if information is same as above and leave section blank.**

Patient First Name:_____ Last Name: _____ Middle Initial: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Cell Phone:(____)_____ Home Phone: (____)_____ Email: _____

Birth Date: _____ Social Security #:_____ Driver's License #:_____

PRIMARY DENTAL INSURANCE INFORMATION: (if none, leave blank)

Name of insured:_____ Insured Social Security #:_____ Insured Birth Date:_____

Insured Relationship to Patient: ☐Self ☐Spouse ☐Parent/Guardian Insured Employer:_____

Insurance Company:_____ Insurance Phone #: (_____)_____

Insurance Company Address:_____

Policy/ ID #:_____ Group #:_____

SECONDARY DENTAL INSURANCE INFORMATION: (if none, leave blank)

Name of insured:_____ Insured Social Security #:_____ Insured Birth Date:_____

Insured Relationship to Patient: ☐Self ☐Spouse ☐Parent/Guardian Insured Employer:_____

Insurance Company:_____ Insurance Phone #: (_____)_____

Insurance Company Address:_____

Policy/ ID #:_____ Group #:_____

CONSENT/HIPAA RELEASE:

I consent to the diagnostic procedures and treatment by the Dentist necessary for proper dental care. I consent to the Dentist's use and disclosure of my records (or my child's) to carry out treatment, obtain payment, and for activities and health care operations that are related. **I consent to the disclosure of my records (or my child's) to the following person(s) who are involved in my care (or my child's) or payment of that care**. My consent to disclose all records shall be effective until I revoke in writing.

1. Name:_____ Relation:_____
2. Name:_____ Relation:_____
3. Name:_____ Relation:_____

Adult Dental History

Patient Name:_____ Birth Date:_____

Previous Dentist's Name:_____ Phone #: (_____)_____

Reason for today's visit:_____

When was your last dental cleaning?_____ How often do you visit the Dentist? _____

Are you in any discomfort at this time?_____

Do you have a fear of dental work?_____

Are you interested in sedation? ☐Nitrous Oxide ☐IV Sedation ☐Unsure ☐No

Would you like to replace any missing teeth?_____

Have you ever had orthodontic treatment? ☐No ☐Invisalign/Clear Aligners ☐Straight Wire Braces

Are your teeth sensitive to any of the following: ☐Heat ☐Cold ☐Sweets ☐Air ☐Pressure

How often do you brush your teeth?_____ How often do you floss?_____

Do you use any of the following: ☐Electric Toothbrush ☐Waterpik ☐Tongue Scraper

Do you wear a sports guard? ☐Yes ☐No & I Play Contact Sports ☐I Don't Play Contact Sports

Do any of the following apply to you:

Wisdom Teeth Present?	☐Yes ☐No	Snore while sleeping?	☐Yes ☐No
Pain in Wisdom Teeth?	☐Yes ☐No	Tested for sleep apnea?	☐Yes ☐No
Bad breath?	☐Yes ☐No	Grind or clench your teeth?	☐Yes ☐No
Bleeding gums?	☐Yes ☐No	Pain in your jaw joints?	☐Yes ☐No
Treated for Periodontal Disease?	☐Yes ☐No	Jaw pop or click?	☐Yes ☐No
Gum surgery/graft?	☐Yes ☐No	Frequent headaches?	☐Yes ☐No
Bite/chew your nails?	☐Yes ☐No	Wake up with headaches?	☐Yes ☐No
Snack throughout the day?	☐Yes ☐No	Tenderness in face muscles?	☐Yes ☐No
Drink sugary drinks?	☐Yes ☐No	Wear a nightguard?	☐Yes ☐No

Are you interested in any of the following: ☐Invisalign ☐Teeth Whitening ☐Botox ☐NightLase

Comments:_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered.

PATIENT/GUARDIAN SIGNATURE:_____ **DATE:** _____

DENTIST'S SIGNATURE:_____ **DATE:**_____

DENTAL HYGIENIST'S SIGNATURE:_____ **DATE:** _____

Adult Medical History

Patient Name:_____ Birth Date:_____

Are you under a physician's care?.....☐Yes ☐No Date of last physical exam:_____

Physician's Name:_____ Physician's Phone #:(____)_____

Have you ever had a serious head or neck injury?.....☐Yes ☐No If yes, explain:_____

Have you ever taken Fen-Phen or Redux?.....☐Yes ☐No If yes, explain:_____

Have you ever taken Fosamax, Zometa, or any other
bisphosphonates for bone tumors or osteoporosis?.....☐Yes ☐No If yes, explain:_____

Have you used tobacco in your lifetime?.....☐Yes ☐No If yes, explain:_____

Do you use controlled substances?.....☐Yes ☐No If yes, explain:_____

Do you consume alcohol daily?.....☐Yes ☐No If yes, explain:_____

Women: Are you...☐Pregnant/trying to get pregnant? ☐Taking birth control pills ☐Nursing

Are you allergic to any of the following? (circle below).....☐**No Known Drug Allergies**

Penicillin	Sulfa	Local Anesthetics	Codeine
Doxycycline	Latex	Metals	Aspirin

Other:_____

Do you have any of the following special needs?

☐ADHD/ADD
☐Anxiety
☐Autism Spectrum
☐Behavioral Disorder
☐Bipolar Depression
☐Blind
☐Cerebral Palsy
☐Deaf
☐Depression
☐Developmental Challenges
☐Down Syndrome
☐Head Injury
☐Multiple Sclerosis
☐Nervous Disorder
☐Psychological Conditions
☐Wheelchair
☐Other_____

Do you have, or have you had, any of the following?

☐Acid Reflux
☐AIDS/HIV+
☐Alzheimer's Disease
☐Anemia
☐Angina/Chest Pains
☐Arthritis/Gout
☐Artificial Heart Valve
☐Artificial Joint/Prosthetic_____
☐Asthma_____
☐Bruise Easily
☐Cancer_____
☐Celiac Disease
☐Chemotherapy_____
☐Crohn's Disease
☐Cold Sores/Fever Blisters
☐Congenital Heart Disorder
☐Cystic Fibrosis
☐Diabetes_____
☐Drug Addiction
☐Eating Disorder
☐Emphysema/COPD
☐Epilepsy or Seizures
☐Excessive Bleeding
☐Fainting Spells/Dizziness
☐Glaucoma
☐Hay Fever/Seasonal Allergies
☐Hearing Loss
☐Heart Attack/Failure_____
☐Heart Murmur
☐Heart Disease
☐Hemophilia
☐Hepatitis_____
☐High/Low Blood Pressure
☐Hypoglycemia
☐Irregular Heartbeat_____
☐Kidney Disease
☐Liver Disease
☐Lung Disease
☐Mitral Valve Prolapse
☐Pacemaker/Defibrillator
☐Psychiatric Care
☐Radiation_____
☐Rheumatic Fever
☐Sexually Transmitted Disease
☐Scleroderma
☐Shingles
☐Sleep Apnea
☐Stomach Problems
☐Stroke_____
☐Thyroid Disease_____
☐Tuberculosis
☐Tumors or Growths
☐Vertigo
Other_____

Comments:_____

Patient Name:____Birth Date:________________________

Please list all surgeries you've had in your lifetime and if you've been hospitalized for a major illness.

____

____

____

____

____

____

____

Please list any medications, supplements, or substances you are taking.

Medication Name	**For What Medical Condition**	**Dosage**

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 patient information, medical status, insurance coverage, and familial status.***

PATIENT/GUARDIAN SIGNATURE:____**DATE:**____________________

DENTIST'S SIGNATURE:____**DATE:**____________________

DENTAL HYGIENIST'S SIGNATURE:______________________________________**DATE:**____________________

INSURANCE, FINANCIAL & APPOINTMENT AGREEMENT

INSURANCE

INSURANCE IS A CONTRACT BETWEEN YOU, YOUR EMPLOYER AND YOUR INSURANCE COMPANY.
Please know your coverage and plan policies prior to services being rendered as we will NOT become involved in major disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, denials, etc. other than to provide information as necessary. We will inform you if we participate with your insurance, we will handle your claims according to our agreement with them, if one exists, and we will help you receive the maximum benefits allowed.
If we DO NOT participate with your insurance, any difference in the fees and insurance amount allowed will be your responsibility on the date of service.

*I understand, (initial here):*_____

PAYMENTS

Payment is due the day of service for all procedures/services that are rendered. Co-payments and deductibles are due for insured patients on the date of service. For procedures that need to be sent to a lab, **the final payment is due before the final insertion appointment.** We accept Visa, MasterCard, Discover, American Express, personal checks and cash. In the event a check is returned for non-sufficient funds, a $30.00 charge will be added to your account. Please inquire about third party payment options if necessary.

*I understand, (initial here):*_____

APPOINTMENT GUIDELINES

If you need to cancel or reschedule your appointment, a minimum of a **24-hour notice** is required. If appointments are cancelled without a 24 hour notice or if you do not show up to your scheduled appointment, a **$50.00 fee** will be added to your account. If you are more than **15 minutes late** to your scheduled start time, you will be rescheduled and may endure a **$50.00 fee**.
Reminder emails, calls and text messages are a courtesy we provide.

*I understand, (initial here):*_____

BREECH OF FINANCIAL AGREEMENT/DELINQUENT ACCOUNTS

Accounts over 90 days will be sent to our collection agency and to credit reporting agencies. A collection fee of 33.3% and any legal costs will be added to the patient account, for which the account holder is responsible for. Account balances over 60 days will be charged a minimum $5.00 billing charge or 1.25% finance charge per month as long as the balance remains. By signing this agreement, I understand in the case of non-payment, a finance charge will be applied each month, and that I will be responsible for any and all collection fees and attorney's fees.

*I understand, (initial here):*_____

HIPAA:
A copy of our Notice of Privacy Practices is available at the front desk if you wish to review it.

*I understand, (initial here):*_____

I authorize payment directly to the Dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental insurance benefits may pay less than the actual bill for services, and that I am responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payor.

PATIENT NAME: _____

PATIENT/GUARDIAN NAME: _____

I ☐give / ☐do not give permission to Wheatfield Family Dentistry to use x-rays or photos of mine or this patient's teeth for educational purposes only on public platforms. (initial here):_____