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:___________________________

Child Medical History

Patient Name:____________________ Birth Date:__________ Parent/Guardian Name(s):____________________

Is the patient under a pediatrician's care?......................☐Yes ☐No Date of last Physical Exam:______________

Physician's Name:________________________________ Physician's Phone #:(____)__________

Has the patient ever had a serious head/neck injury?.....☐Yes ☐No If yes, explain:____________________

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

Penicillin Sulfa Local Anesthetics Codeine

Doxycycline Latex Metals Aspirin

Other:____

Does the patient have any of the following special needs?

☐ADHD/ADD ☐Bipolar Depression ☐Depression ☐Wheelchair

☐Anxiety ☐Blind ☐Down Syndrome ☐Other__________

☐Autism Spectrum ☐Cerebral Palsy ☐Nervous Disorder

☐Behavioral Disorder ☐Deaf ☐Speech Impairments

Does the patient have, or have they ever had, any of the following?

☐Anemia ☐Cystic Fibrosis ☐Kidney Problems

☐Artificial Heart Valve ☐Diabetes______________ ☐Liver Disease

☐Artificial Prosthetic ☐Eating Disorder ☐Lung Disease

☐Asthma ☐Epilepsy or Seizures ☐Mitral Valve Prolapse

☐Blood Transfusion ☐Excessive Bleeding ☐Psychiatric Care

☐Bruise Easily ☐Fainting Spells/Dizziness ☐Radiation______________

☐Cancer______________ ☐Heart Murmur ☐Stomach Problems

☐Celiac's Disease ☐Hemophilia ☐Tonsillitis

☐Chemotherapy__________ ☐Hepatitis ☐Tumors or Growths

☐Cold Sores/Fever Blisters ☐Hypoglycemia Other______________

☐Congenital Heart Disorder ☐Irregular Heartbeat

Comments:____

____

Please list all surgeries the patient has had in their lifetime and if they've been hospitalized for a major illness.

____

____

Please list any medications, supplements, or substances they patient is 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 the 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.***

PARENT/GUARDIAN SIGNATURE:________________________________**DATE:**__________

DENTIST'S SIGNATURE:________________________________**DATE:**__________

DENTAL HYGIENIST'S SIGNATURE:________________________________**DATE:** __________

Child Dental History

Patient Name:______________________ Birth Date:___________ Parent/Guardian Name(s):______________

Previous Dentist's Name:_______________________________________ Phone #: (________)___________

Reason for today's visit:____

When was the patient's last dental cleaning?_____________ How often do they visit the Dentist? ___________

Is the patient in any discomfort at this time?____

Does the patient have a fear of dental work?____

Has the patient ever received a local anesthetic in the dental setting? ☐Yes ☐No

Has the patient ever had orthodontic treatment? ☐No ☐Invisalign/Clear Aligners ☐Straight Wire Braces

Do they wear a retainer? ☐No ☐Yes, wears consistently ☐Yes, doesn't wear consistently

Do they wear a sportsguard? ☐Yes ☐No & Plays Contact Sports ☐Doesn't Play Contact Sports

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

How often do they brush their teeth?__________________ How often do they floss?_____________________

Circle one: Does the patient brush *independently* or with *parental assistance*?

Do any of the following apply to the patient:

Suck their thumb?	☐Yes ☐No	Mouth breather?	☐Yes ☐No
Use a pacifier?	☐Yes ☐No	Bad breath?	☐Yes ☐No
Bite/chew their nails?	☐Yes ☐No	Bleeding gums?	☐Yes ☐No
Chew hard objects?	☐Yes ☐No	Grind or clench their teeth?	☐Yes ☐No
Snack throughout the day?	☐Yes ☐No	Pain in their jaw?	☐Yes ☐No
Drink juice/soda throughout the day?	☐Yes ☐No	Jaw pop or click?	☐Yes ☐No
Take gummy vitamins?	☐Yes ☐No	Frequent headaches?	☐Yes ☐No
Snore while sleeping?	☐Yes ☐No		

Comments:____

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____

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

PARENT/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):________