Patient Registration

Date: _____ Patient Name: _____

Date of Birth: _____ SS # _____ Male _____ Female _____

Marital Status: Single _____Married _____Separated _____Divorced _____Widowed_____

Home Address: _____ City: _____State: _____ Zip: _____

Home # _____ Cell # _____ Work # _____

Email Address_____ (For Appointments)

Preferred way to be Contacted: Text _____ Email _____ Phone Call_____

Are you a **College** Student: Full Time ____ Part Time____ College Name: _____

If patient is a minor, who is legally responsible? _____

Relationship _____ Phone # _____

In case of Emergency, who should we contact? _____

Emergency # _____ Relationship: _____

Were you referred, If Yes who may we thank? _____

How did you hear about us: Internet ____Flyer ____ Community Event_____ Other_____

Insurance Information:

Do you have Insurance for us to bill for you today: Yes _____ No_____

Subscriber's Name: _____ Subscriber's Employer: _____

Name of Insurance Co: _____ Insurance Phone #: _____

Date of Birth: _____ SS# _____ Subscribers ID # _____

Group # _____Relationship to Subscriber: _____

Does patient have a **Secondary** insurance? Yes _____ No _____

Subscriber's Name: _____ Subscriber's Employer: _____

Name of Insurance Co: _____ Insurance Phone #: _____

Date of Birth: _____ SS# _____ Subscribers ID # _____

Group # _____Relationship to Subscriber: _____

** I hereby authorize payment of the dental and insurance benefits and authorize the release of dental information to my insurance company in order for claims to be processed. I have received and signed the financial policy.

_____ _____

Patient or Guardian Signature Date

DELUXE™ DENTAL

Medical History

Are you under medical treatment now?

If so, please explain: _____ Treating Physician: _____

Have you ever been hospitalized for any surgery or serious illnesses? Yes _____ No_____ If Yes, what?_____

Have you ever taken any Bisphosphonate drugs such as Fosamax, Actonel, Boniva, or Reclast? Yes ___ No ___

Have you ever taken Fen-Phen (Phentermine)? Yes ___ No___ Do you need to Pre Med? Yes _____ No___

MEDICATIONS

Are you currently taking medications? Yes___ No___

If yes, what: _____

MEDICAL CONDITIONS

__ Heart Attack/Surgery __ Hepatitis/Jaundice __ Arthritis __ Heart Murmur

__ Kidney Disease __ Glaucoma __ Heart Disease/Pacemaker __ Tobacco User

__ Fainting __ Chest Pains __ Thyroid Problems __ Epilepsy/Convulsions

__ High/Low Blood Pressure __ Stomach Problems __ HIV/Aids __ Rheumatic Fever

__ Leukemia/Anemia/Blood Disorder __ Stroke __ Herpes Simplex I or II __ Drug/Alcohol Abuse

__Tuberculosis __ Cancer __ Radiation/Chemotherapy __ Asthma/Respiratory

__ Hay Fever __Diabetes, Which Type:_____ Other:_____

__Full/Partial Joint Replacement If yes, When?_____ Which Joint?_____

WOMAN ONLY: Are you Pregnant/Breastfeeding? Yes __ No__ Are you taking birth control? Yes __ No__

ALLERGIES:

__ Aspirin/Ibuprofen __ Penicillin __ Sulfa __ Codeine __ Sedative __ Iodine __ Latex __ Local Anesthetic

Other: _____

PATIENT DENTAL HISTORY

When was your last dental visit? _____ Name of previous Dentist? _____

Dental History:

Yes __ No __ Are you having pain/discomfort as this time?

Yes __ No __ Have you had any problems with your Jaw?

Yes __ No __ Do your gums bleed when you brush?

Yes __ No __ Do you clench or grind your teeth?

Yes __ No __ Are you aware of any lumps in your mouth?

Yes__ No__ Earaches, Headaches Neck Pain?

Yes__ No__ Teeth or Fillings Breaking?

Yes__ No__ Bad Breath or Bad taste?

Yes__ No__ Have you ever had a bad experience in a dental office in the past?

What would you like to improve?

Whiten _____

Straighten _____

Close Spaces _____

Replace Silver Fillings _____

Repair Chip Teeth _____

Replace Missing Teeth _____

Replace Old Crowns_____

Do You have any of the Following?

Yes__ No__ Do you wear denture, partial or retainer?

Yes__ No__ Do you have braces?

Yes__ No__ Do you have a gum disease (Periodontal)?

** I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information may be detrimental to my health.

Patient /Guardian Signature_____ Date_____

Financial Policy

Thank you for choosing Deluxe Dental as your dental care provider!

Our professional dental team is committed to providing you excellent dental care in a friendly, comfortable setting. The following is a statement of our financial policy, which we request that you read and sign prior to treatment.

Full payment is due at the time of service, unless other arrangement has been made. We accept cash, check, debit card, Visa, MasterCard, Discover, American Express and Carecredit. Interest on balance unpaid beyond 90 days will be applied at the rate of 1.5% monthly (18% annually).

While we do accept assignment of insurance benefits, your portion of each service is due at the time services are rendered. This may be based on an **estimate** of insurance payment, not a guarantee of payment. Your insurance policy is a contract between you, your employer and your insurance company. We are not a party to that contract. We do, however, submit dental claims as a courtesy to our patients and will do our best to assist you in understanding and applying your dental benefits. We cannot guarantee insurance payments or payment amounts. All treatment estimates are provided based upon information from your insurance company and are estimates only. If your insurance company has not paid your account in full within 90 days of billing, we will require the balance to be paid directly by you via cash, check, debit or credit cards.

Treatment plan are created based upon clinical findings during your diagnostic exam and are subject to change based upon clinical need and/or our treatment schedule.

Our policy is to charge for missed appointments or appointments that are not cancelled less than a **24 hour notice** at the rate of **$25.00** per appointment. Please help us serve you better by keeping scheduled appointments.

Return checks are subject to an additional fee of **$25.00**.

Unpaid balances are subject to action by a collection agency.

Signature on File

By signing below, I give my permission for Deluxe Dental to release necessary information regarding my treatment to by insurance company(s) and assign dental benefit payments directly to Deluxe Dental.

If you have any further questions regarding our financial policy, please ask a member of our dental team.

I UNDERSTAND AND AGREE TO COMPLY WITH THIS FINANCIAL POLICY.

Print Patient Name: _____ Date: _____

Patient/Guardian Signature: _____ Relationship to Patient: _____

Hipaa

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

(Please Initial one of the following)

**** I have received a copy of this office's notice of Privacy Practices ____**

**** I have reviewed the notice of Privacy Practices, but declined my copy ____**

Print Patient Name: _____ Date:_____

Patient/Guardian Signature:_____ **Relationship to Patient:**_____

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 acknowledgement**
- **An emergency situation prevented us from obtaining acknowledgment**
- **Other (please specify): _____**

Employee Signature: _____ Date: _____