# PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

IF THIS APPOINTMENT IS FOR YOU START HERE

## 1

DATE

LAST NAME | FIRST | M.I.

PREFERS TO BE CALLED BY

ADDRESS

CITY | STATE | ZIP

HOME PHONE NO. | FAX

CELL | EMAIL

BIRTHDATE | AGE | MALE | FEMALE

MARRIED | SINGLE | DIVORCED | WIDOWED

SOCIAL SECURITY NO.

IF THIS APPOINTMENT IS FOR YOUR CHILD START HERE

DATE

LAST NAME | FIRST | M.I.

ADDRESS

CITY | STATE | ZIP

HOME PHONE NO.

BIRTHDATE | AGE | MALE | FEMALE

SCHOOL | GRADE

SOCIAL SECURITY NO.

IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO

## 2 DENTAL INSURANCE

### PRIMARY CARRIER

INSURANCE COMPANY

GROUP NO.

EMPLOYER NAME

INSURED'S NAME

DATE OF BIRTH | RELATIONSHIP TO PATIENT

INSURED'S I.D. NO.

INSURED'S SOCIAL SECURITY NO.

### SECONDARY CARRIER

INSURANCE COMPANY

GROUP NO.

EMPLOYER NAME

INSURED'S NAME

DATE OF BIRTH | RELATIONSHIP TO PATIENT

INSURED'S I.D. NO.

INSURED'S SOCIAL SECURITY NO.

## 3 GETTING TO KNOW YOU

IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?

NAME: | RELATIONSHIP:

YOU WERE REFERRED TO US BY

YOUR FORMER ADDRESS

CITY | STATE | ZIP

PERSON TO CONTACT FOR EMERGENCY

PHONE NUMBER

ADDRESS

CITY | STATE | ZIP

CLOSEST RELATIVE NOT LIVING WITH YOU

PHONE NUMBER

ADDRESS

CITY | STATE | ZIP

## 4 ACCOUNT INFORMATION

### PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

NAME

RELATIONSHIP TO PATIENT | SOCIAL SECURITY NO.

ADDRESS

CITY | STATE | ZIP

PHONE NO.

### YOU

NAME

OCCUPATION

EMPLOYER'S NAME

ADDRESS | CITY

PHONE NO. | FAX NO.

### YOUR SPOUSE

NAME

OCCUPATION

EMPLOYER'S NAME

ADDRESS | CITY

PHONE NO. | FAX NO.





*Please turn over and sign*

# CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Patient's Signature _____ Date _____ Witness _____

Parent/Responsible Party's Signature _____ Relationship to Patient ____

# MEDICAL HISTORY

Patient Name _____

Medical Alert _____

1. Physician's Name_____ Phone (  ) _____
   Have you had any medical care within the past two years? ……. Yes No
   Describe _____
2. Have you taken any medication or drugs during the past two years? ……..... Yes No
3. Are you currently taking any medication, drugs, pills or herbal remedies, including regular dosages of aspirin? …….. Yes No
   If yes, please list name and dosage _____
4. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other similar drugs? …… Yes No
5. Are you aware of having an allergic (**or adverse**) reaction to any substance or medication? ……. Yes No
   If yes, please specify _____
6. Have you been a patient in the hospital during the past five years? ……..... Yes No
7. Indicate which of the following you have, or had at present. Circle "yes" or "no" to each item.

| | | | | | |
|---|---|---|---|---|---|
| Heart (Surgery, Disease, Attack) … | Yes No | Ulcers …… | Yes No | Sickle Cell Disease..... | Yes No |
| Artificial Joints (hips, keen, ect) …. | Yes No | A.I.D.S/H.I.V Positive …….. | Yes No | Bruise Easily …… | Yes No |
| Chest Pain ……... | Yes No | Thyroid Problems ……. | Yes No | Liver Disease/Yellow Jaundice …….. | Yes No |
| Congenital Heart Disease …… | Yes No | Glaucoma ……... | Yes No | Neurological Disorders ……... | Yes No |
| Diabetes ……... | Yes No | Emphysema ……... | Yes No | Fainting or Dizzy Spells ……..... | Yes No |
| Heart Murmur ……. | Yes No | Chronic Cough …….. | Yes No | Nervous/Anxious …… | Yes No |
| High Blood Pressure ……..... | Yes No | Tuberculosis …….. | Yes No | Psychiatric/Psychological Care ……. | Yes No |
| Low Blood Pressure ……..... | Yes No | Asthma …….. | Yes No | Diet (Special/Restricted) …… | Yes No |
| Mitral Valve Prolapse ……..... | Yes No | Sinus Trouble …… | Yes No | Arthritis/Rheumatism …… | Yes No |
| Artificial Heart Valve/Pacemaker … | Yes No | Epilepsy or Seizures …….. | Yes No | Cortisone Medicine ……... | Yes No |
| Hepatitis A B C (circle) …… | Yes No | Hay Fever/Allergy/Hives …….. | Yes No | Swollen Ankles ……. | Yes No |
| Rheumatic Fever ……. | Yes No | Kidney Trouble …….. | Yes No | | |
| Stroke …….. | Yes No | Venereal Disease ……... | Yes No | | |
| Radiation Therapy …….. | Yes No | Cold Sores/Fever Blisters …….. | Yes No | | |
| Chemotherapy ……. | Yes No | Blood Transfusion …….. | Yes No | | |
| Tumors …… | Yes No | Hemophilia …….. | Yes No | | |

8. Have you lost or gained more than 10 pounds in the past year? …….. Yes No
9. Do you have or had any disease, condition, or problem not listed? ……. Yes No
   If yes, please list: _____
10. **Women:** Are you pregnant or think you could be pregnant? Yes _____ Months No **Nursing?** Yes No
11. Do you use birth control prescriptions? ……. Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of knowledge. Should further information be needed, you have my permission to ask the respective health care providers or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.

Patient/Guardian Signature _____ Date _____

Dentist Signature _____ Date _____

**History Review**

Patient: _____ Date: _____ , BP: _____ , Dentist: _____, Date: _____

Patient: _____ Date: _____ , BP: _____ , Dentist: _____, Date: _____

Patient: _____ Date: _____ , BP: _____ , Dentist: _____, Date: _____

Patient: _____ Date: _____ , BP: _____ , Dentist: _____, Date: _____

Patient: _____ Date: _____ , BP: _____ , Dentist: _____, Date: _____

Patient Name _____

# DENTAL HISTORY

Medical Alert _____

*Welcome! So that we may provide you with the best possible care, please complete both sides of this medical/dental history form. All information is completely confidential.*

**What is the reason for you visit today?**

_____

**Date of Last Dental Visit** _____ **Last Dental Cleaning** _____ **Last Full Mouth X-rays** _____

**How often do you have dental examinations?** _____

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

Have your ever used or are currently using topical fluoride? Yes No

What other dental aids do you use? (Interplak, toothpick, ect.) _____

**Do you have dental problems now?** Yes No

If yes, please describe: _____

**Are any of your teeth sensitive to:**

| | | |
|---|---|---|
| Hot or cold? | Yes | No |
| Sweets? | Yes | No |
| Biting or Chewing? | Yes | No |
| Have you noticed any mouth or bad tastes? | Yes | No |
| Do you frequently get cold sores, blisters or any other oral lesions? | Yes | No |
| Do your gums bleed or hurt? | Yes | No |
| Have your parents experienced gum disease? | Yes | No |
| Or tooth loss? | Yes | No |
| Have your noticed any loose teeth or change In your bite? | Yes | No |
| Does food tend to become caught in between Your teeth? | Yes | No |

If yes, where? _____

**Do you:**

| | | |
|---|---|---|
| Clench or grind your teeth while awake or sleep? | Yes | No |
| Bite your lips or cheeks regularly? | Yes | No |
| Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails) | Yes | No |
| Mouth breathe while awake or asleep? | Yes | No |
| Have tired jaws, especially in the morning? | Yes | No |
| Snore or have any other sleeping disorders? | Yes | No |
| Smoke/chew tobacco or use other tobacco products? | Yes | No |

**Have you ever had:**

| | | |
|---|---|---|
| Orthodontic treatment (braces)? | Yes | No |
| Periodontal treatment (gums)? | Yes | No |
| Oral surgery? | Yes | No |
| Your teeth ground or the bite adjusted? | Yes | No |
| A bite plate or mouth guard? | Yes | No |
| A serious injury to the mouth or head? | Yes | No |

If so, please describe, including cause _____

_____

**Have you experienced:**

| | | |
|---|---|---|
| Clicking or popping for the jaw? | Yes | No |
| Pain? (joint, ear, side, of face)? | Yes | No |
| Difficulty in opening or closing the mouth? | Yes | No |
| Difficulty in chewing on either side of the mouth? | Yes | No |
| Headaches, neckaches or shoulder aches? | Yes | No |
| Sore muscles (neck, shoulders)? | Yes | No |

**What would you like to change about your smile?**

_____

_____

Do you feel nervous about having dental treatment? Yes No

If so, what is your biggest concern?

_____

Have you ever had an upsetting dental experience? Yes No

If yes, please describe _____

_____

**Have you ever been told to take a pre-medication prior to dental treatment?** Yes No

**Is there anything else about having dental treatment that you would like us to know?** Yes No

If yes, please describe _____

# SLEEP SURVEY

Patient Name: _____ Date: _____

*This questionnaire was developed based upon the published findings of the American Academy of Sleep Medicine (AASM). The purpose of this questionnaire is to aid a qualified medical professional identify possible symptoms of a sleep disorder and is not meant to be used as a substitute for any diagnostic procedure.*

| | | |
|---|---|---|
| Y/N | 8 | Have you ever been told you stop breathing while asleep? |
| Y/N | 6 | Have you ever fallen asleep or nodded off while driving? |
| Y/N | 6 | Have you ever woken up suddenly with shortness of breath, gasping or with your heart racing? |
| Y/N | 4 | Do you feel excessively sleepy during the day? |
| Y/N | 4 | Do you snore, or have ever been told that you snore? |
| Y/N | 2 | Have you had weight gain and found it difficult to lose? |
| Y/N | 2 | Have you taken medication for, or have been diagnosed with high blood pressure? |
| Y/N | 3 | Do you kick or jerk your legs while sleeping? |
| Y/N | 3 | Do you feel burning, tingling or crawling sensations in your legs when you wake up? |
| Y/N | 3 | Do you wake up with headaches during the night or in the morning? |
| Y/N | 4 | Do you have trouble falling asleep? |
| Y/N | 4 | Do you have trouble staying asleep once you fall asleep? |
| | | Score and Risk Factor |

| Low | Moderate | High | Severe |
|---|---|---|---|
| 0-7 | 8-11 | 12-15 | 16+ |

**Visual Indications**

□ Enlarged/Scalloped Tongue □ Retruded Lower Jaw □ High Arching Hard Palate

□ Gastroesophageal Reflux □ Enlarged Tonsils □ Bruxism

Have you ever been diagnosed with a sleep disorder? Y/N

Are you currently using a CPAP machine? Y/N

If yes, do you use it every night? Y/N

**Notes**

# COSMETIC CONCERNS

Patient Name: _____ Date: _____

*Helping you with your concerns is very important to us. Please take a moment to let us know how you feel about the appearance of your smile.*

Which of the following concerns do you have?

- ☐ Crooked teeth
- ☐ Uneven teeth
- ☐ Short, worn teeth
- ☐ "Gummy" teeth
- ☐ Chipped teeth
- ☐ Missing teeth
- ☐ Spaces between teeth
- ☐ Discolorations, stains or spots
- ☐ Not as white as I want them to be
- ☐ Old silver fillings
- ☐ I have older restorations that I do not like

Does the appearance of your teeth embarrass you? ☐ Yes ☐ No

What concerns you the most about the appearance of your teeth?

_____

_____

_____

_____

_____

_____

_____

## Acknowledgement of Receipt of Notice of Privacy Practices

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of the Plaza Dental Notice of Privacy Practices.

_____ [Please Print Name]

_____ [Signature]

_____ [Date]

If this Acknowledgement is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's name

Relationship to Patient _____

## For Program 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
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

plaza dental

# FINANCIAL POLICY

Thank you for selecting us as your dental care provider. We are committed to the highest level of quality, preventive treatment. Please understand that payment for services is part of your treatment. Please read our financial policy outlined below, and sign it before seeing the doctor.

1. Full payment is due at the time of service, unless previous arrangements have been made.
2. We accept cash, check, Visa/Mastercard, American Express, Discover, and Care Credit.
3. If you have a dental benefit, your estimated portions, co-pays, and/or deductibles are due at the time of service.
4. With prior arrangements, we offer extended payment plans. Financing fees may apply. Discounts cannot be combined.

Our practice is committed to providing the best treatment based on the diagnosis of what is needed to save and prevent further loss or damage to your gums and teeth. Our diagnosis will not be based on what your insurance company will cover, or how economical the treatment will be, but in the best interest of your dental and health care.

If we are provided with all the necessary information, we will accept assignment of dental insurance benefits. This information must be provided before treatment begins. You will be expected to pay your estimated portion at the time services are rendered. ***Please be advised this is only an estimate.*** The actual amount could vary depending on what your insurance pays or unexpected changes in treatment. Although we strive to provide the most accurate estimates, you are responsible for any balance for services rendered. Your insurance policy is a contract between your employer and your insurance company, and we are not a party to that agreement. Until your insurance company has paid their portion of services rendered, the unpaid balance may appear on your monthly statement. If there is a delay in processing your claims with your insurance company, you may be asked to pay the balance in full after 60 days and be reimbursed once the insurance claim is finalized.

If financial arrangements are made to include a payment plan, we expect you to adhere to this agreement strictly. To prevent finance or re-billing charges, we ask that you comply with your original financial arrangement. This will eliminate all of the extra time for processing and the embarrassment or awkwardness of collecting on treatment that has been rendered.

A finance charge of 1.5% per month (18% annually) will be added to any balance that is more than 60 days overdue. If your account becomes delinquent for more than 60 days and you are in need of additional treatment, full payment must be made prior to the time of service.

# APPOINTMENT POLICY

We make every attempt to schedule appointments for our patients in a manner that reduces waiting time and provide prompt and attentive service to each and every patient. Appointment times are reserved especially for you and we make every effort to be ready for you at your appointment time. We expect our patients to respect their scheduled appointment times and make every effort to be on time as we are for you.

We do require a 48 business-hour notice for any appointment change. A broken appointment is a loss to you and prevents us from providing you with needed preventative and restorative care. It is a loss to the patient who could have had that appointment time. And, it is a loss to our team who prepared for your visit. Keeping your scheduled appointments and being on time is an important part of what contributes to our team providing the care our patients are accustomed to. We realize changes need to be made occasionally, but respectfully ask for your attention to this matter. A broken appointment fee may apply if advance notice of 48 business-hours is not received to change an appointment. Certain appointments may require an initial payment to reserve an appointment, which will be applied towards treatment or forfeited if appointment is changed without proper notice.

Patient Signature _____ Date _____

Parent, Guardian, or Responsible Party_____ Relationship _____