

PATIENT REGISTRATION FORM

Date of Appointment: _____

Referred By: _____

Personal Information

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

(Preferred Name: _____) DOB: ____/____/____ Single [] Married [] Child [] Other []

SS# _____ Sex: Male [] Female [] E-mail: _____

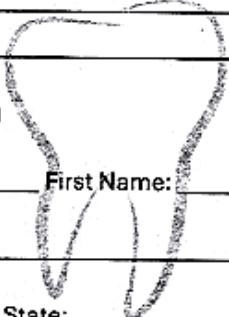
Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: (Home) _____ (Cell) _____

Emergency Contact Info: (Name/Relationship) _____

(Telephone Number) _____



Responsible Party/Guardian (If other than patient)

Last Name: _____ First Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: (Home) _____ (Cell) _____

Email: _____ Relationship to Patient: _____

Handwritten text: marietta

Insurance Information

Contact Info: (Company) _____ (Phone Number) _____

Handwritten text: DENTAL CENTER

Group Name: _____ Group Number: _____

Subscriber's Full Name: _____ DOB: ____/____/____

Member ID Number: _____

Notice of Information Change

I (Patient/Guardian) _____, understand that it is my responsibility to notify Marietta Dental Center of any changes to my or my dependent's personal, medical, or insurance information **PRIOR TO ANY FUTURE APPOINTMENTS**. I also understand that failure to do so may result in: lengthened appointment times and/or may incur large, out-of-pocket balances due to rejected insurance claims.

Patient/Guardian Signature: _____ Date: _____

PATIENT DENTAL AND MEDICAL HISTORY

Dental History

Reason for today's visit: _____ Date of last visit: _____

Former Dentist: _____ Date of last x-rays: _____

Please check box if you have/had:

- Bad breath []
- Blisters on lips or mouth []
- Burning sensation on tongue []
- Chew on one side of mouth []
- Cigarette, pipe, or cigar smoking []
- Smokeless tobacco []
- Dry mouth []
- Food collection between teeth []
- Clench teeth []
- Grind teeth []
- Growth or sore spots in mouth []
- Gums swollen, tender, or bleeding []
- Head, neck, or jaw pain or aches []
- Lip or cheek biting []
- Loose teeth or broken filling []
- Mouth breathing []
- Orthodontic treatment []
- Periodontal treatment []
- Sensitivity to pressure or irritants (cold, heat, sweets) []
- How often do you floss? _____
- How often do you brush? _____

Have you ever had an allergic reaction to Novacaine, local or general anesthetics? If yes, please explain:

Have you had trouble from previous dental care? If yes, please explain what happened:

Medical History

PCP name: _____ Date of last visit: _____

Physician's address: _____

Physician's fax/phone number: _____

Have you ever had a blood transfusion? If yes, please describe:

Have you had any serious illness or operations? If yes, please give approximate dates:

Pregnant? Y/N If yes, please give approximate due date: _____ Nursing? Y/N Birth Control? Y/N

Please check box if you have/had:

- | | | | |
|--|--|----------------------------------|--|
| Allergies [] | Emphysema [] | Mitral Valve Prolapse [] | Ulcer [] |
| Anemia [] | Epilepsy [] | Osteopenia [] | Venereal Disease [] |
| Arthritis [] | Fainting [] | Osteoporosis [] | Weight Loss Unexplained [] |
| Artificial Heart Valves [] | Glaucoma [] | Pacemaker [] | Do you wear contact lenses? [] |
| Artificial Joints [] | Headaches [] | Radiation Treatments [] | Do you consume alcoholic beverages? [] |
| Asthma [] | Heart Murmur [] | Respiratory Disease [] | Are you under the care of a Physician? [] |
| Bleeding abnormally during surgery [] | Heart Problems [] | Fever [] | Are you allergic to latex? [] |
| Blood Disease [] | Hepatitis [] (type: _____) | Shortness of Breath [] | Allergic to Penicillin, Aspirin, or Other Drugs? [] |
| Clotting Disorder [] | Herpes [] | Sinus Trouble [] | If yes, please specify: |
| Cancer [] | High Blood Pressure [] | Sickle Cell Anemia [] | _____ |
| Chemotherapy [] | Any Immune Deficiency (incl. HIV/AIDS) [] | Stroke [] | _____ |
| Circulatory Problems [] | Jaundice [] | Swelling of Feet/Ankles [] | Are you currently taking any Medications? [] |
| Cough [] | Kidney Disease [] | Thyroid Problems [] | If yes, please list: |
| Diabetes [] | Low Blood Pressure [] | Tonsillitis [] | _____ |
| | | Tuberculosis [] | _____ |
| | | Tumor or Growth on Head/Neck [] | _____ |

I, (patient/guardian name) _____, have read and answered the above questions to the best of my knowledge.

Patient/Guardian Signature: _____ Date: _____

PREFERRED PHARMACY

To better serve you, your prescriptions will now be electronically processed directly to your pharmacy. Please provide us with your pharmacy information in the space provided below. If at any time there is a change in your pharmacy information, please provide us with updated information as soon as possible. We appreciate your cooperation.

Pharmacy Name: _____

Pharmacy Address: _____

City: _____ State: _____ Zip: _____

Pharmacy Phone Number: _____

marietta
D E N T A L C E N T E R

I, (patient/guardian name) _____, have read and answered the above questions to the best of my knowledge.

Patient/Guardian Signature: _____ Date: _____

FINANCIAL AGREEMENT

We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health. The following is a statement of our Financial Policy, which we require that you read, agree to, and sign prior to any treatment. We are pleased to discuss our professional fees with you at any time. Your clear understanding of the Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility upon arrival at your first appointment.

ADULT PATIENTS

Adult patients are responsible for full payment at time of service.

MINORS ACCOMPANIED BY AN ADULT

The adult accompanying a minor, his/her parents or guardians, are responsible for full payment at time of service.

INSURANCE

We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company.

Please understand that we will provide an insurance estimate to you, however, it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits will determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time. If you are paid by the insurance company instead of our practice, you then become responsible for the total account balance and payment would be expected immediately.

We ask that you sign this form and/or any other necessary documents that may be required by your insurance company.

DEDUCTIBLE/CO-PAYMENT

We may ask that you pay the deductible and co-payment, which is the estimated amount, not covered by your insurance company, by cash, check, credit card or Patient Financing at the time we provide the service to you.

MEDICARE/ MEDICAID/ CHAMPUS/ WORKER'S COMPENSATION

If you are covered by Medicare, Medicaid, CHAMPUS, Worker's Compensation or any other government sponsored program, please discuss your payment situation with our office staff prior to arriving at the office on the date of service.

DELINQUENT PAYMENTS

It is our policy to charge a finance fee for outstanding patient balances. In addition, all payments returned due to non-sufficient funds will be subject to a fee.

MISSED APPOINTMENTS

Unless cancelled in advance, our policy is to charge a fee for missed appointments. Please help us service you better by keeping scheduled appointments.

REFUND POLICY

You may discontinue treatment and request a refund at any time for any amount that you paid for treatment that you did not receive. Please contact your office if you'd like to request a refund.

Patient/Guardian Signature: _____ Date: _____

CONSENT

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize the release of any information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I authorize the release of any information concerning my (or my child's) health care, advice and treatment to another dentist.

I understand that I may withdraw or revoke my authorization at any time. I may revoke this authorization by notifying my practice in writing.

I understand that by signing this Consent form, I am giving my consent to disclose and discuss my protected health information to carry out treatment, payment activities and health care operations.

The undersigned hereby authorizes Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read, understand and agree to the above terms and conditions.



Patient/Guardian Signature: _____ Date: _____