Harrisville Dental Associates

3 pages

Patient Registration Information
CONFIDENTIAL

Name: ______________________________ Date: __________
First Middle Last

WELCOME TO OUR PRACTICE!
Thank you for selecting our dental healthcare team. Please fill out this form completely in ink. If you have any questions or concerns, please do not hesitate to ask for assistance-we will be happy to help!

Patient Information

Home Address__________ City__________ State__________ Zip__________

Birthdate__________ Gender: Male / Female SSN__________ Home __________

E-Mail__________ Cell Phone__________

Are you: Minor Single Married Divorced Widowed Separated

Your or your parent/guardian's employer __________ Occupation__________

Business Address __________ City __________ State__________ Zip__________

Spouse or parent/guardian's name __________ Employer__________ Work Phone __________

If you are a student, name of school/college __________ City__________ State__________

☐

Whom may we thank for referring you? __________

Person to contact in a case of an emergency? __________

Responsible Party

Name of person responsible for this account__________ Relationship__________

Address: __________ City__________ State__________ Zip__________

Home Phone:__________ Cell Phone: __________ SS # __________

Driver's License #__________ Birthdate__________ Financial Institution__________

Employer__________ Work Phone__________

Is this person currently a patient in our office? Yes__________ No__________

Dental Insurance Information

Name of Insured__________
Relationship to patient__________ D/O/B__________ SS#__________ Date Employed__________
Address of Employer__________ City__________ State__________ Zip__________
Insurance Company__________ Ins. Company Address__________
Group#__________ ID#__________ How much is your deductible?__________
How much have you used?__________ Annual Maximum Benefit__________

Do you have additional Dental Insurance?__________

ALL ANSWERS ARE STRICTLY CONFIDENTIAL

TO THE PATIENT: Your answers are important for the protection of your health and that of the staff of *Harrisville Dental Associates.* Please answer the following questions about your health for our files. Your answers are important for your treatment.

Medical Conditions

YES NO Hepatitis-Type **A,B,C** or **Delta**
YES NO Diabetes: insulin dependent or diet controlled
YES NO Patient in the hospital in the past 2 years
YES NO Artificial Joint Replacement
YES NO Kidney Disease/Transplant/Dialysis
YES NO Cancer: Type:_______________
YES NO Chemotherapy/Radiation Therapy Date:_______
YES NO **Are you Allergic To Any Medicines?**
If YES, Please List Below:
____
____
YES NO High Blood Pressure
YES NO Venereal Disease-Date_______________
YES NO Do you use smokeless tobacco?
If YES, how frequently? _______________
YES NO Are you undergoing Psychiatric Treatment?
YES NO Abnormal Bleeding
YES NO Are you Pregnant or Nursing?
If YES Due Date: ___________________

YES NO Low Blood Pressure
YES NO Asthma
YES NO Tuberculosis
YES NO Seizures
YES NO Stroke: Date:_______________
YES NO Hyperthyroidism
YES NO Slow-Healing or Mouth Sores?
YES NO Do you smoke?
If YES, how much?_______________
YES NO Kidney Disease
YES NO Blood Disease? What Kind___________
YES NO Tested positive for HIV
If YES, Date:_______________
YES NO Malignant Hyperthermia
YES NO Do you use Alcohol
If YES, how frequently?_______________
YES NO Recurrent Illness?
YES NO Have you ever taken Fen-Phen for weight loss?

YES NO Are you taking birth control (*NOTE: in combination with antibiotics your birth control pills may become **ineffective**).
YES NO Are you taking Viagra(*Note: in the event of a heart attack, administration of nitroglycerin will be **FATAL!**)
YES NO **Are you taking any medications?**
If yes, for what purpose(s)? Please list below:

Name Of Drug	Purpose

Heart Problems

YES NO Murmurs
YES NO Bypass Surgery
YES NO Heart Attack-Date:_______
YES NO Pacemaker
YES NO Angina Pectoris
YES NO Rheumatic Fever
YES NO Artificial Valves
YES NO Mitral Valve Prolapse
YES NO Heart Stent? When placed?
YES NO Abnormal Heart or
YES NO Previous Bacterial Endocarditis

Doctors Comments
____
____
Drs.Signature_______________
Date: _______________

Are you taking any of these Medications? Please Circle

Antacids
Tagamet (cimetidine) or Prilosec
Dilantin or Tegretol
Barbiturates
St. John's Wart or Kava-Kava
Cardizem (diltiazem) or Calan, Isoptin (verapamil)
Serzone (nefazodone)
Diflucan (fluconazole) or Sporonox (itraconazole)
Biaxin (clarithromycin)

Are You Allergic To Any Of The Following? Please Circle

Local Anesthetics **Sulfa Drugs** **Latex Allergy** **Other :**___________	**Barbiturates** **Sedatives** **Codeine/Valium** **Aspirin, Ibuprofen, Tylenol**	**Iodine** **Penicillin or other** **Antibiotics**___________ _______________

Circle any of the following if you have had or have at present

Scarlet Fever Liver Disease Sinus Trouble Bruise Easy	Ulcers Alcoholism Allergies/Hives Nervous Disorder	Emphysema Drug Addiction Cold Sores Fainting	Cough Pain in Jaw Sickle Cell Anemia Mental Retardation	Epilepsy Glaucoma Rheumatism Arthritis	Hemophilia Birth Defects Dizzy Spells Hay Fever	Thyroid Disease Anemia Seizures Cortisone Meds.

When was your last physical examination? _______________Physician's Name? _______________
Has there been any change in your general health in the past year? ______If yes, for what reason? _______________
Are you now under a physician's care? _______________If yes, for what condition? _______________
Is there anything related to your medical history that you have not indicated above? If yes, please explain:_______________
Which pharmacy location do you use? _______________

Dental History

When was your last professional cleaning/exam? _______________X-rays_________
What is your chief concern? _______________

YES NO Are you having pain or discomfort at this time?
YES NO Do you have trouble chewing?
YES NO Do your gums bleed when you floss or brush?
YES NO Have you been told you have gum disease?
YES NO Do you dislike anything about your smile?
YES NO Do you feel nervous about dental treatment?
YES NO Have you ever had orthodontic treatment?
YES NO **Have you been advised to take antibiotics prior to dental treatment?**
YES NO Do you have dental implants?
YES NO Do you have frequent Headaches?

ATTENTION PATIENTS

You Are Responsible For Knowing Your Dental Insurance Benefits

Dental plans differ significantly. Each patient should know and understand his or her individual benefit package. Please contact your insurance company at the telephone number on your insurance card if you have questions regarding your coverage.

Patients with dental insurance are responsible for paying any co-payment, deductible, or fees for non-covered services at the time the services are rendered. We will be happy to give you an estimated treatment plan, however this is ***only an estimate*** and the patient is ultimately responsible for any payment not covered by insurance.

To help you get the most from your dental plan, we encourage you to become familiar with your insurance plan before seeking care.

X____ ______________

Signature of patient or parent/guardian if minor **Date**

AUTHORIZATION, RELEASE & AGREEMENT TO PAY FOR SERVICES RENDERED

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such Dental Care to third party payors and/or other health practitioners.

I authorize and hereby request insurance company to pay directly to the dentist (or the dental group) insurance benefits otherwise payable to me.

I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependent(s). I understand that I am signing, giving permission and acknowledgment of dental procedures to be performed on myself or dependent(s)

X____ ______________

Signature of patient or parent/guardian if minor **Date**

FINANCIAL ARRANGEMENTS

Your financial portions for treatment rendered, are due at time of service. We do offer payment plans and discounts for qualifying services to help you achieve your optimum dental health. Let us know any financial concerns prior to your appointments. We are happy to help you.
Please ask us about Care Credit, specials we are running right now, and discount offers that may apply to you!

CARD#______________________________EXPIRATION DATE____________

REGARDING MISSED AND CANCELLED APPOINTMENTS

We strive to deliver our Best services at the most convenient times for our patients. It is for this reason we offer **LATE EVENING & WEEKEND** hours. This is why we will impose a **$100 "MISSED APPOINTMENT" fee PER HOUR** on appointments not cancelled and/or rescheduled within a timely manner. We ask that you kindly provide us with at least a **48-HOUR NOTICE OF CANCELLATION.**

X____ ______________

Signature of patient or parent/guardian if minor **Date**