

DENTAL INNOVATIONS PATIENT REGISTRATION

PATIENT:

First Name: _____ Last Name: _____ Middle Initial: _____
Patient Is: Policy Holder Responsible Party Preferred Name: _____

RESPONSIBLE PARTY (if not the patient)

First Name: _____ Last Name: _____ Middle Initial: _____
Address: _____ Address 2: _____
City, State, Zip: _____
Home Phone: _____ Work Phone: _____ Cell: _____
Birth Date: _____ Soc Sec: _____ Drivers Lic: _____
 Responsible Party is also a Policy Holder for Patient Primary Insurance Policy Holder Secondary Insurance Policy Holder

PATIENT INFORMATION

Address: _____ Address 2: _____
City: _____ State / Zip: _____
Home Phone: _____ Work Phone: _____ Cell: _____ I would like to receive texts.
Sex: Male Female Marital Status: Married Single Divorced Separated Widowed
Birth Date: _____ Age: _____ Soc Sec: _____ Drivers Lic: _____
E-mail: _____ I would like to receive e-mail.
Employment Status: Full Time Part Time Retired Previous Dentist: _____
Student Status: Full Time Part Time Date of most recent cleaning/exam: _____
Medicaid ID: _____ Previous Xrays? _____
Employer ID: _____ Pref. Pharmacy: _____
Carrier ID: _____ How did you hear about us? _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other
Insured Soc. Sec: _____ Insured Birth Date: _____
Employer: _____ Ins. Company: _____
Address: _____ Address: _____
Address 2: _____ Address 2: _____
City, State, Zip: _____ City, State, Zip: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other
Insured Soc. Sec: _____ Insured Birth Date: _____
Employer: _____ Ins. Company: _____
Address: _____ Address: _____
Address 2: City, State, Zip: _____ Address 2: _____
City, State, Zip: _____ City, State, Zip: _____

Patient Signature: _____ Date: _____

DENTAL INNOVATIONS PATIENT MEDICAL HISTORY

Patient Name: _____

Date of Birth: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Have you ever been hospitalized or had a major operation?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Have you ever had a serious head or neck injury?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Are you taking any medications, pills, or drugs?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Do you take, or have you taken, Phen-Fen or Redux?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Are you on a special diet?	<input type="radio"/> Yes <input type="radio"/> No		
Do you use tobacco?	<input type="radio"/> Yes <input type="radio"/> No		

Women: Are you...

Pregnant/Trying to get pregnant?
 Nursing?
 Taking oral contraceptives?

Are you allergic to any of the following?

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Codeine	<input type="checkbox"/> Acrylic
<input type="checkbox"/> Metal	<input type="checkbox"/> Latex	<input type="checkbox"/> Sulfa Drugs	<input type="checkbox"/> Local Anesthetics

Other? If yes

Do you use controlled substances? Yes No If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No	Hemophilia <input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No	Diabetes <input type="radio"/> Yes <input type="radio"/> No	Hepatitis A <input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No	Drug Addiction <input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No
Anemia <input type="radio"/> Yes <input type="radio"/> No	Easily Winded <input type="radio"/> Yes <input type="radio"/> No	Herpes <input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No
Angina <input type="radio"/> Yes <input type="radio"/> No	Emphysema <input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Rheumatism <input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No	High Cholesterol <input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No	Hives or Rash <input type="radio"/> Yes <input type="radio"/> No	Shingles <input type="radio"/> Yes <input type="radio"/> No
Artificial Joint <input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No
Asthma <input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No
Blood Disease <input type="radio"/> Yes <input type="radio"/> No	Frequent Cough <input type="radio"/> Yes <input type="radio"/> No	Kidney Problems <input type="radio"/> Yes <input type="radio"/> No	Spina Bifida <input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No	Leukemia <input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No
Breathing Problems <input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No	Liver Disease <input type="radio"/> Yes <input type="radio"/> No	Stroke <input type="radio"/> Yes <input type="radio"/> No
Bruise Easily <input type="radio"/> Yes <input type="radio"/> No	Genital Herpes <input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No
Cancer <input type="radio"/> Yes <input type="radio"/> No	Glaucoma <input type="radio"/> Yes <input type="radio"/> No	Lung Disease <input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No
Chemotherapy <input type="radio"/> Yes <input type="radio"/> No	Hay Fever <input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No	Tonsillitis <input type="radio"/> Yes <input type="radio"/> No
Chest Pains <input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No	Osteoporosis <input type="radio"/> Yes <input type="radio"/> No	Tuberculosis <input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No	Heart Murmur <input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No	Ulcers <input type="radio"/> Yes <input type="radio"/> No
Convulsions <input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No	Venereal Disease <input type="radio"/> Yes <input type="radio"/> No
			Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No

Have you ever had any serious illness not listed Yes No If yes

Comments:

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 my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian: _____

X

Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement*

I, _____, have received a copy of this
office's Notice of Privacy Practices.

Please Print Name

Signature

Date

For Office 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)

DENTAL INNOVATIONS FINANCIAL POLICY

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Our fees are based on the quality materials we use and the time, effort, and skill required in performing your needed treatment. The following is a statement of our financial policy which we require that you read and sign prior to any treatment. Please understand that regardless of any insurance status, you are responsible for the balance due on your account. You are responsible for the cost of any and all services rendered.

PAYMENT

Full payment is due at the time of service. If insurance benefits apply, your estimated patient responsibility amount is due at the time of service.

INSURANCE

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy to you, our office is happy to assist in contacting your insurance company for pre-treatment estimates, upon your request. It is impossible for us to have knowledge and keep track of every aspect of your insurance. It is up to you to contact your insurance company and inquire as to what benefits you have. If you have any questions concerning coverage or estimates for services, it is your responsibility to contact your insurance company for answers prior to treatment. Please be aware some or perhaps all of the services provided may not be covered by your insurance policy. Any balance is your responsibility whether or not your insurance company pays any portion. Again, based on estimated insurance coverage, your patient responsibility amount is due at the time of service.

WE ACCEPT CARE CREDIT

An option for payment is Care Credit. Care Credit has offered interest-free payment plans of up to 24 months and payment plans with interest for terms up to 60 months – any plan is subject to their terms and conditions. Our practice accepts Care Credit but we have no influence on their promotions or terms. Please apply with Care Credit directly on their website (carecredit.com) or with them on the phone at 1-800-677-0718.

MISSED APPOINTMENTS

When you make an appointment, our dental professional reserves time on their calendar for you. Please be respectful to keep the appointment or provide notice of cancellation at least 24 hours in advance. If you don't provide at least 24 hours' notice of cancellation, you will be charged \$50.00. This fee is not billable to insurance or Medicaid. Please help us service you better by keeping scheduled appointments.

PATIENT PHOTO and INFORMATION RELEASE

I hereby authorize Dental Innovations to take photographs, slides and/or videos of my face, jaw and teeth. I understand that the photos, slides and/or videos will be used as a record of my care and may be used for educational purposes in lectures, demonstrations, advertising and professional publications, including website publication. I further understand that the photos, slides and/or videos used may include my name or other identifying information. I do not expect compensation, financial or otherwise, for the use of these photographs.

_____ I **CONSENT** to having my name, photos, slides and/or videos released

_____ I **CONSENT** to having only my photos, slides and/or videos released

PATIENT/RESPONSIBLE PARTY: _____

RESPONSIBLE PARTY SIGNATURE: _____ **Date** _____