PATIENT REGISTRATION AND MEDICAL HISTORY

(Please print)

Date_____ Home (_____)_____Cell (____)_____

Have you or anyone in your immediate family ever been here before?_____ Who?_____

Patient:_____

Last Name First Name Middle Initial Preferred Name

Street Address _____ City _____ State_____ ZIP _____

E-Mail _____

Male_____ Female _____ Married _____ Single _____ Other_____

Date of Birth_____ Age _____ Social Security Number _____

Employer/School _____ Occupation_____

Employer/School Address_____ Employer/School Phone (____)_____

Spouse/Parent Name _____ SS#_____ Birth Date _____

Spouse/Parent Employed by _____Occupation _____

Business Address _____Business Phone _____

Emergency Contact _____Contact Phone _____

Whom may we thank for referring you? _____

Are you in pain today or have any special concern? _____

When is the last time you've been to the dentist? ____ For what?_____Former Dentist?_____

Primary Insurance Company:_____ID#_____Group#_____

Name of Insured:_____SS#_____Birth Date _____

Relationship to Patient _____

MEDICAL HISTORY

Physician's Name_____ Date of last Physical_____

Have you ever had any of the following (check all that apply)

___Artificial Heart Valves, joints, screws	___Allergies/Sinus Problems	___Arthritis
___Congenital Heart Lesions	___Back Problems	___Cancer
___Heart Murmer	___Chemical Dependency	___Diabetes Type I /II
___Heart Problems	___Circulatory Problems	___Hepatitis, jaundice, liver disease
___Hemophilia/bleeding problems	___Epilepsy	___Radiation Treatment
___High or Low blood pressure	___Nervous Problems	___Stroke
___Mitral Valve Prolapse	___Psychiatric Care	___Swollen Neck Glands
___Pacemaker	___Respiratory Disease	___HIV/AIDS
___Rheumatic Fever/ Scarlet Fever	___Ulcer	___Venereal Disease

Do you have trouble sleeping? _____ Do you snore? _____

Do you smoke? _____ Or use any other tobacco products? _____

Do you have any drug allergies or ever had an adverse reaction to any medication or anesthesia?_____

If so, what?_____

Have you ever responded adversely to medical or dental treatments? How?_____

Are you taking medication at this time?_____ If so, what? _____

Have you ever taken fen-phen or any other similar diet pill? _____

Are you currently under the care of a physician?_____ If so, for what?_____

If patient is a child, what is his/her weight? _____

(***Women***) *Do you suspect you are pregnant?_____Due date_____ Nursing? ____ Taking birth control?____*

Is there anything else we should know about your medical history?_____

MINOR/CHILD CONSENT

I am the parent, guardian, or personal representative of _____and there

Please Print Name of Minor/ Child

are no court orders in effect that prohibit me from signing this consent. I hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, administration of anesthetics, nitrous (laughing gas), and fluoride treatment, which are deemed advisable by the doctor, whether or not I am present when treatment is rendered. If my child is under the age of 18 I understand that I will have to accompany them to all appointments.

INSURANCE ASSIGNMENT AND RELEASE

I certify that the person listed on the other side is covered by the insurance that I have stated and assign directly to Dr. Sharon Patrick and Associates all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

FINANCIAL AGREEMENT

I acknowledge that payment in full is due at the time of treatment unless other arrangements have been made prior to the appointment. Payments may be made by cash, checks, or most major credit cards. I accept full financial responsibility for all charges for services or items provided to me or to the patient. I understand that "A Confident Smile" will be happy to file my primary insurance claims as a **courtesy.** However, I am responsible for the deductibles, and the estimated co-pays that insurance plan using usual customary fees. I am responsible regardless of my insurance company's arbitrary determination of usual and customary rates. I understand some and perhaps all of the services provided may be non-covered services and may not be considered reasonable and necessary under my insurance plan. I understand that it is my responsibility to make sure payment from the insurance company is made within 30 days. After 30 days, if the insurance has not paid on the claim, I will be notified by either phone or mail to pay the balance in full within 30 days or an 18% APR may be added. After 60 days, the account may be turned over to a collection agency. **I understand that my insurance policy is a contract between me and my insurance company and that "A Confident Smile" is not a party to this contract.**

BROKEN APPOINTMENTS

I understand that an appointment time slot is something that should not be wasted, as the **doctor and staff have set aside time** to treat me. I realize that if I am more than 15 minutes late, this will be considered a broken appointment and may not be able to be rescheduled. I agree to give a 48-hour notice if I should need to cancel or move my appointment and understand **if I do not, I will be charged $40 for time lost and I may be asked to seek care with another dental provider.**

RETURN CHECK FEE

I understand there is a **$30 returned check fee** for a check that is returned to the office. I also understand that having returned checks will jeopardize my being able to use a personal check.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

BY SIGNING THIS, I AM STATING THAT I HAVE READ AND AGREE TO THE TERMS ABOVE, AND RECEIVED A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES AND MAY TAKE IT HOME WITH ME.

_____ _____ _____

Print Patient's Name | Signature of Responsible Party | Date

We appreciate you for being a patient in our office, and we thank you for your patience and understanding.