PATIENT REGISTRATION

PATIENT INFORMATION

first name	m.i.	last name
address		
city,state, zip		
date of birth	SSN	
sex ☐M ☐F	driver's license	
marital status: ☐Married ☐Single ☐Divorced ☐Separated ☐Widowed		
employment status: ☐full-time ☐part-time ☐retired ☐N/A		
student status: ☐full-time ☐part-time		

CONTACT INFORMATION

home phone
cell phone
work phone
email
How would you like to be contacted?
By providing your cell phone number, you consent to being contacted at that number by our practice and our agents regarding treatment and your account.

RESPONSIBLE PARTY (if other than patient)

first name	m.i.	last name
address		
city, state, zip		
date of birth	SSN	
relationship to patient		
cell phone	home phone	
email		

IN CASE OF EMERGENCY

name
relationship
phone

DENTAL INSURANCE (primary)

name of insured
relationship to patient
employer
insurance company
insurance phone number

DENTAL INSURANCE (secondary)

name of insured
relationship to patient
employer
insurance company
insurance phone number

How did you hear about us?

☐Insurance company ☐Employer ☐Internet

☐Another patient ☐Other _____

I certify that I and/or my dependent(s) have insurance coverage with _____ and assign directly to Plaza Dental Group 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.

Plaza Dental Group may use my health care information and may disclose such information to the above-named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____

signature of patient, parent, guardian, or representative

_____

print name of patient, parent, guardian, or representative

_____ _____

relationship date

HEALTH HISTORY

Patient Name

Are you under a physician's care?	YES NO	If yes, please explain:
Have you ever been hospitalized or had a major operation?	YES NO	
Have you ever had a serious head or neck injury?	YES NO	
Do you use tobacco?	YES NO	
Do you use controlled substances?	YES NO	

MEDICATIONS

List any medications and the correlating diagnosis:

_____

_____

_____

_____

_____

_____

_____

Are you taking or have you ever taken:

Aspirin on a DAILY basis?	YES NO
Bisphosphonates? (Fosamax, Boniva, Actonel, Atelvia, etc.)	YES NO
Diet Medications? (Redux, Phen-Fen, Pondimin, etc.)	YES NO

ALLERGIES

Are you allergic to any of the following?

Aspirin	YES NO	Penicillin	YES NO
Barbiturates	YES NO	Latex	YES NO
Codeine	YES NO	Local Anesthetic	YES NO
Iodine	YES NO	Sulfa	YES NO

Other _____

WOMEN

Are you:

Pregnant / Trying to get pregnant?	YES NO
Nursing?	YES NO
Taking Oral Contraceptives?	YES NO

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

****To the best of my knowledge, the questions on this form have been answered accurately.**

**Patient Signature _____ date _____ Dentist Signature _____

UPDATE (to be filled in at a future appointment)

Has there been any change to your health since the last visit?	YES NO
For what conditions?	
Are you taking any new medications?	YES NO
If so, what?	

Patient Signature _____ date _____

UPDATE (to be filled in at a future appointment)

Has there been any change to your health since the last visit?	YES NO
For what conditions?	
Are you taking any new medications?	YES NO
If so, what?	

Patient Signature _____ date _____

Welcome to Plaza Dental Group. We are committed to providing you with the best and most comprehensive dental care and to helping you achieve your optimum oral health. An important part of this mission is making the cost of optimal care as easy and manageable for our patients as possible.

PATIENT RESPONSIBLITIES

Payment: Payment is due at the time services are rendered. Financial arrangements are discussed during the initial visit and a financial agreement is completed in advance of performing any treatment with our practice. We accept the following forms of payment: Cash, Check, Visa, Mastercard, American Express, and Care Credit.

* Please note:

- If you elect to apply for third-party financing, administered through our practice, we are required by law to provide you with a Credit for Dental Services Notice.
- There will be a $25 fee for all returned checks.

Dental Benefit Plans: Your dental benefit is a contract between you or your employer and the dental benefit plan. Benefits and payments received are based on the terms of the contract negotiated between you or your employer and the plan. We are happy to help our patients with dental benefit plans to understand and maximize their coverage.

Our practice IS / IS NOT (circle one) a contracted provider with your dental benefit plan.

If we are a contracted provider with your plan, you are responsible only for your portion of the approved fee as determined by your plan. We are required to collect the patient's portion (deductible, co-insurance, co-pay or any amount not covered by the dental benefit plan) in full at time of service. If our estimate of your portion is less than the amount determined by your plan, the amount billed to you will be adjusted to reflect this.

If we are not a contracted provider with your dental benefit plan, it is the patient's responsibility to verify with the plan whether the plan allows patients to receive reimbursement for services from out-of-network providers. If your plan allows reimbursement for services from out-of-network providers, our practice can file the claim with your plan and receive reimbursement directly from the plan if you "assign benefits" to us. In this circumstance, you are responsible and will be billed for any unpaid balance for services rendered upon receipt of payment from the plan to our practice, even if that amount is different than our estimated patient portion of the bill. If you choose to not "assign benefits" to our practice, you are responsible for filing claims and obtaining reimbursement directly from your dental benefit plan and will be responsible for payment to our practice before or at the time of service.

any individually identifiable health information and other sensitive or confidential information that may be contained in such email may be misdirected, disclosed to or intercepted by unauthorized third parties. However, you may consent to receive unsecured email from us regarding your treatment. We will use the minimum necessary amount of protected health information in any communication. Our first email to you will verify your email address.

_____I prefer to receive information via the practice's secure communication methods. My email address is _____ .

_____I consent and accept the risk in receiving information via unencrypted email. I understand I can withdraw my consent at any time. I consent to receiving appointment reminders via unencrypted email. I understand the minimum necessary information is used in these reminders. I understand I can withdraw my consent at any time. My email address is _____ .

_____I do not consent to receiving any information via email. I understand that I can change my mind and provide consent later.

Cellphone:
I consent to the dental practice using my cellphone number to call or text regarding appointments and to call regarding treatment, insurance and my account. I understand that I can withdraw my consent at any time. My cellphone number is _____. _____ (initial)

PATIENT ACKNOWLEDGEMENTS

I hereby acknowledge that a copy of Plaza Dental Group's **Notice of Privacy Practices** has been made available to me. I have been given the opportunity to ask any questions I may have regarding this notice.

_____

Patient Name

_____

Signature of Patient, Parent, or Guardian date

I hereby acknowledge that a copy of the **Dental Materials Facts Sheet** has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Fact Sheet.

_____

Patient Name

_____

Signature of Patient, Parent, or Guardian date