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.

Scheduling of Appointments: We reserve the doctor and hygienist's time on the schedule for each patient procedure and are diligent about being on time. Because of this courtesy, when a patient cancels an appointment, it affects the overall quality of service we are able to provide. To maintain the utmost service and care, we do require 48-hour notice to reschedule an appointment. With less than 48-hour notice, a fee of $25 or deposit to reserve the appointment time again, may be required. To serve all of our patients in a timely manner, we may need to reschedule an appointment if a patient is 15 minutes late or more arriving to our practice.

PATIENT AUTHORIZATIONS AND CONSENT

CONSENT TO TREATMENT AND CHANGES IN TREATMENT I authorize this dental team to perform any necessary dental services that I may need and have consented to during diagnosis and treatment. I understand that during the course of treatment, it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. I give my permission to make any changes and additions as necessary. **initial_____

DENTAL PROCEDURES I am aware that dentistry is not an exact science, and acknowledge that no guarantee has been made to me about the results of my dental procedures. I understand that there are rare risks associated with any dental treatment or surgery, including swelling, bleeding, infection, and numbness and / or tingling of the lips, tongue, or face. **initial_____

DRUGS AND MEDICATION I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and / or anaphylactic shock. **initial_____

FINANCES AND APPOINTMENT SCHEDULING I have read the above and agree to the financial and scheduling terms. **initial_____

INSURANCE I authorize the release of information necessary to process my dental benefit claims. I hereby authorize payment directly to this doctor otherwise payable to me. YES / NO (circle one) **initial_____

PATIENT COMMUNICATION

Voice Messages:

I understand brief messages from the dental practice may be left on my home answering machine or with anyone who answers the telephone at my home unless I have provided the practice with alternate instructions for communication. _____ (initial)

Email:

Except for appointment reminders, we use secure methods to electronically communicate with our patients. Unencrypted email is not a secure form of communication. There is some risk that

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