Patient Registration

PATIENT NAME (Last, First, Middle Initial)		DATE OF BIRTH
ADDRESS		SOCIAL SECURITY NUMBER
CITY, STATE, ZIP		MARITAL STATUS ☐Single ☐Married
HOME PHONE	CELL PHONE	SEX ☐Male ☐Female
DO YOU PREFER: ☐Morning Appointments ☐Afternoon Appointments		RELATIONSHIP TO INSURED ☐Self ☐Spouse ☐Child
EMPLOYER		WORK PHONE
OCCUPATION		E-MAIL ADDRESS

Who should be notified locally in case of emergency?

NAME	PHONE
ADDRESS	

Referred to this office by:

NAME	PHONE

Insurance Information

Primary Coverage	Secondary Coverage
SUBSCRIBER'S NAME	SUBSCRIBER'S NAME
DATE OF BIRTH	DATE OF BIRTH
INSURANCE COMPANY	INSURANCE COMPANY
SOCIAL SECURITY NUMBER	SOCIAL SECURITY NUMBER
GROUP NUMBER	GROUP NUMBER
LOCAL NUMBER OR POLICY NUMBER	LOCAL NUMBER OR POLICY NUMBER
EMPLOYER	EMPLOYER
OCCUPATION	OCCUPATION
SIGNATURE	DATE

Benefits (For Office Use Only)

Calendar Year _____ Yearly Plan Maximum $_____ Deductible $ _____ Class 1_____% Class 2 _____% Class 3_____% Coverage for: FMX _____Prophy_____ Sealants_____ BW _____ Fluoride _____ MTC:	Calendar Year _____ Yearly Plan Maximum $_____ Deductible $ _____ Class 1_____% Class 2 _____% Class 3_____% Coverage for: FMX _____Prophy_____ Sealants_____ BW _____ Fluoride _____ MTC:

Electronic Payor ?_____ Payor ID: _____ Mail Claims to: _____

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? Excellent Good Fair Poor

DO YOU HAVE or HAVE YOU EVER HAD: **YES NO**

1. hospitalization for illness or injury _____
2. an allergic or bad reaction to any of the following:
   - aspirin, ibuprofen, acetaminophen, codeine
   - penicillin
   - erythromycin
   - tetracycline
   - sulfa
   - local anesthetic
   - fluoride
   - metals (nickel, gold, silver, _____)
   - latex
   - nuts _____
   - fruit _____
   - other _____
3. heart problems, or cardiac stent within the last six months ___
4. history of infective endocarditis _____
5. artificial heart valve, repaired heart defect (PFO) _____
6. pacemaker or implantable defibrillator _____
7. orthopedic implant (joint replacement) _____
8. rheumatic or scarlet fever _____
9. high or low blood pressure _____
10. a stroke (taking blood thinners) _____
11. anemia or other blood disorder _____
12. prolonged bleeding due to a slight cut (INR > 3.5) _____
13. pneumonia, emphysema, shortness of breath, sarcoidosis ___
14. tuberculosis, measles, chicken pox _____
15. asthma _____
16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus)
17. kidney disease _____
18. liver disease _____
19. jaundice _____
20. thyroid, parathyroid disease, or calcium deficiency _____
21. hormone deficiency _____
22. high cholesterol or taking statin drugs _____
23. diabetes (HbA1c = _____) _____
24. stomach or duodenal ulcer _____
25. digestive or eating disorders (e.g., celiac disease, gastric reflux, bulimia, anorexia) _____

YES NO

26. osteoporosis/osteopenia (i.e. taking bisphosphonates) ___
27. arthritis _____
28. autoimmune disease _____ (i.e. rheumatoid arthritis, lupus, scleroderma)
29. glaucoma _____
30. contact lenses _____
31. head or neck injuries _____
32. epilepsy, convulsions (seizures) _____
33. neurologic disorders (ADD/ADHD, prion disease) _____
34. viral infections and cold sores _____
35. any lumps or swelling in the mouth _____
36. hives, skin rash, hay fever _____
37. STI/STD/HPV _____
38. hepatitis (type ____) _____
39. HIV/AIDS _____
40. tumor, abnormal growth _____
41. radiation therapy _____
42. chemotherapy, immunosuppressive medication _____
43. emotional difficulties _____
44. psychiatric treatment _____
45. antidepressant medication _____
46. alcohol/recreational drug use _____

ARE YOU:

47. presently being treated for any other illness _____
48. aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea) _____
49. taking medication for weight management _____
50. taking dietary supplements _____
51. often exhausted or fatigued _____
52. experiencing frequent headaches _____
53. a smoker, smoked previously or use smokeless tobacco ___
54. considered a touchy/sensitive person _____
55. often unhappy or depressed _____
56. taking birth control pills _____
57. currently pregnant _____
58. diagnosed with a prostate disorder _____

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

_____

List all medications, supplements, and or vitamins taken within the last two years.

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

ASA _____ (1-6)

DENTAL HISTORY

Name _____ Nickname _____ Age _____
Referred by _____ How would you rate the condition of your mouth? Excellent Good Fair Poor
Previous Dentist _____ How long have you been a patient? _____ Months/Years
Date of most recent dental exam _____ /_____ /_____ Date of most recent x-rays _____ /_____ / _____
Date of most recent treatment (other than a cleaning) _____ / _____ / _____
I routinely see my dentist every: 3 mo. 4 mo. 6 mo. 12 mo. Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING: **YES** **NO**

PERSONAL HISTORY

1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____] _____
2. Have you had an unfavorable dental experience? _____
3. Have you ever had complications from past dental treatment? _____
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____
5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age? _____
6. Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma? _____

GUM AND BONE

7. Do your gums bleed or are they painful when brushing or flossing? _____
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____
9. Have you ever noticed an unpleasant taste or odor in your mouth? _____
10. Is there anyone with a history of periodontal disease in your family? _____
11. Have you ever experienced gum recession? _____
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth? _____

TOOTH STRUCTURE

14. Have you had any cavities within the past 3 years? _____
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____
17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth? _____
18. Do you have grooves or notches on your teeth near the gum line? _____
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____
20. Do you frequently get food caught between any teeth? _____

BITE AND JAW JOINT

21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____
22. Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together? _____
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? _____
24. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed? _____
25. Are your teeth becoming more crooked, crowded, or overlapped? _____
26. Are your teeth developing spaces or becoming more loose? _____
27. Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together? __
28. Do you place your tongue between your teeth or close your teeth against your tongue? _____
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____
30. Do you clench or grind your teeth together in the daytime or make them sore? _____
31. Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth? ___
32. Do you wear or have you ever worn a bite appliance? _____

SMILE CHARACTERISTICS

33. Is there anything about the appearance of your teeth that you would like to change (shape, color, size)? _____
34. Have you ever whitened (bleached) your teeth? _____
35. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____
36. Have you been disappointed with the appearance of previous dental work? _____

Patient's Signature _____ Date _____
Doctor's Signature _____ Date _____

DISCOVERY DENTAL

ACKNOWLEDGMENT
OF
PRIVACY PRACTICES

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.

Obtain payment from third party payers for my health care services.

Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my dental provider's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand that my dental provider has the right to change the Notice of Privacy Practices and that I may contact this office at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree with my restrictions, but if you do then you are bound to abide by such restrictions.

Patient Name: _____ Date: _____

Signature: _____

Relationship to Patient: _____

Dependant family members that are also covered by this acknowledgment:

_____

_____

For Office Use Only:
We were unable to obtain the patient's written **acknowledgment** of our Notice of Privacy Practices due to the following reasons:

- ☐ The patient refused to sign
- ☐ Communication Barriers
- ☐ Other
- ☐ Emergency Situation

Financial Arrangements and Office Policy

For All Patients:

A payment for services rendered is expected at the time of your appointment. Cash, personal checks, Visa and MasterCard are all accepted. If an extended payment plan is desired, please ask us about our third party billing (finance) program. All unpaid accounts will be assessed a 1% monthly finance charge after 60 days. Delinquent accounts over 90 days could be referred to a collection agency. All fees incurred from the collection agency will be charged to the account.

For Patients with Dental Insurance:

At Discovery Dental, we accept almost all dental insurance. As a complementary service we will file your claim with your insurance company. We will estimate your deductible and the portion not covered by your insurance. Our estimates may differ somewhat from your insurance company's calculations; therefore, the amount due at our office may be adjusted accordingly. All procedures that are not covered by insurance are ultimately the patient's responsibility. Any insurance claims denied or remaining unpaid after 60 days will automatically become the responsibility of the patient and will result in a 1% monthly finance charge. I hereby authorize my insurance benefits to be paid directly to the physician. I also authorize the doctor or insurance company to release any information required for processing any claims.

Office Policy:

If the need to cancel a scheduled appointment arises, we request at least 48 hours' notification. Appointments cancelled within 48 hours or "No-Show" appointments will result in a $50 fee charged to your account. Please turn off all cell phones prior to entering the treatment area. Interruptions of dentist and assistant can affect the quality of treatment.

Our Promise:

Above all, the primary goal of our dental office is to provide high quality, "patient-centered" dental care. We strive to maintain our standards through patient service, professionalism, compassion, efficiency and continuing education. We will also make every effort to "stay on time" so that you will not have to wait. Every staff member takes pride in achieving high standards in dental excellence and values forming lasting relationships with our patients. We are honored to have you as our patient and will make every effort to exceed your expectations.

Madhuri Vanama, DDS and Staff

Print Name

Signature and Date