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## Patient Registration Form

Last Name: _____ First Name: _____

### Contact Information

Phone (Cell): _____-_____-_____

Phone (Home): _____-_____-_____

Email:

_____

Would you like to receive e-mail and text reminder? _____

### Address Information

Address Line:

_____

City: _____ State:_____ Zip: _____

### Patient Information

Sex: _____ Birthdate: _____

Social Security: _____ Marital Status: _____

### Responsible Party (If different from patient)

Full Name: _____ DOB: _____
SSN: _____

Street Address: _____

City: _____ State: _____ Zip:
_____ Phone: _____

### Emergency Contact

Name of Contact: _____ Phone Number: _____

Relationship: _____

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## Payment Information

- I plan to use insurance
- I do not have dental insurance and am interested in the Dental Membership Plan
- I do not have dental insurance and am interested in CareCredit

## Primary Insurance Information

Subscriber Name: _____

Subscriber DOB: _____ Subscriber SSN: _____

Insurance Name: _____

Group #: _____Policy #: _____

Employer Name: _____Relationship to Subscriber: _____

Phone # on back of care that says “For Providers” _____

## Secondary Insurance Information

Subscriber Name: _____

Subscriber DOB: _____ Subscriber SSN: _____

Insurance Name: _____

Group #: _____Policy #: _____

Employer Name: _____Relationship to Subscriber: _____

Phone # on back of care that says “For Providers” _____

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Are you allergic to any of the following?

____Aspirin ___Penicillin ___Codeine ___Acrylic ___Metal ___Latex ___Other

_____

*Any health problems you may be experiencing or medication you may be taking could impact your dental care. Please carefully read through the following questions and answer as accurately as possible. Thank you!*

Are you under the care of a physician YES NO

If yes, please include name and office number:

_____

I have been hospitalized or have required a major operation within the last 5 years

YES NO

If yes, please explain

_____

- I smoke or chew tobacco
- I require a premed for dental appointments
- Are you taking or ever taken bisphosphonates? (Fosama or Actonel for Osteoporosis)

If yes, please explain

_____

Please list all current medications/Or Write "See List" If You Have Provided A List:

_____

_____

_____

_____

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Do you have or had any of the following?

- AID/HIV
- Alzheimer's
- Anaphylaxis
- Anemia
- Angina
- Arthritis/Gout
- Artificial Heart Valve
- Artificial Joint
- Asthma
- Blood Disease
- Blood Transfusion
- Cancer
- Chemotherapy
- Chest Pains
- Cold Sores
- Congenital Heart Disorder
- Cortisone Medications
- Crohn's Disease
- Diabetes
- Drug Addiction
- Epilepsy or Seizures
- Excessive Bleeding
- Emphysema
- Frequent Headaches
- Frequent Cough
- Genital Herpes
- Glaucoma
- Heart Murmur
- Hives or Rash
- Heart Pacemaker
- Hepatitis A
- Hepatitis B or C
- Hypoglycemia
- Heart Disease
- Hay Fever
- Heart Attach
- Hemophilia
- High Blood Pressure
- Herpes
- Irregular Heart Beat
- Intestinal Disease
- Kidney Problems
- Leukemia
- Liver Disease
- Psychiatric Disease
- Rheumatism
- Radiation
- Rheumatic Fever
- Shingles
- Sickle Cell
- Stroke
- Sinus Problems
- Swelling Limbs
- Scarlet Fever
- Tonsillitis
- Tuberculosis
- Tumors or Growths
- Thyroid Disease
- Venereal Disease
- Yellow Jaundice

Have you had a serious illness not listed above? _____

Woman: Are you currently:

- Pregnant
- Trying To Get Pregnant
- Nursing?
- Taking oral contraceptives?

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Smile Questionnaire: If you could change something about your smile what would it be?

Select all that apply:

- Whiter
- Straighter
- Replace missing teeth
- Close space
- Repair chipped teeth
- Replace black mercury fillings with tooth colored fillings
- Replace old crowns that do not match

Dental History: Please select all that apply:

- Snoring
- Clenching and grinding
- Halitosis (chronic bad breath)
- Frequent headaches
- Fatigue or tired throughout the day
- Tooth sensitivity

I give my permission to discuss my dental treatment (including but not limited to: Treatment, Scheduling, Billing, Insurance, etc.) with the following:

_____

**Who May We Thank For Your Referral?

_____

Signature of Responsible Party

I have read a copy of this office's Notice of Privacy Practices. By signing this form, I consent for your office to use and disclose my protected health information to carry out treatment, payment activities and healthcare operations. I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I agree that I am responsible for all services rendered to the patient and the payment is due and payable to the Practice at the time services are rendered. I understand that while the Practice will file claims with my insurance company on my behalf, I remain responsible to the Practice for what is not paid by my insurance company.

X_____

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## Assignment and Release

I the undersigned, have insurance with _____, and assign directly Yunbelievable Smiles all 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits.

## Patient Agreement and Financial Policy

I hereby agree to be responsible for the costs of care provided by Yunbelievable Smiles and/or the dental team for myself or my dependent(s). These include any deductibles and amounts not covered by insurance. ***I also understand that it is my responsibility to be aware of any limitations, and benefits of my insurance policy***. Payment to this office is my responsibility and I am aware that if the insurance company does not reimburse the doctor, I am responsible for the total amount(s).

I understand that there will be a $35 charge to all accounts in which a check payment is returned.

I understand that because appointments are not double-booked, I must provide notice of cancellation at least 48 hours prior to my scheduled appointment time. ***For appointments scheduled for less than 60 minutes, a cancellation fee of $50 may apply if I do not provide notice of cancellation at least 24 hours prior to my scheduled appointment time.***

We make every effort to schedule appointments that are most convenient for you and that fit your personal schedule. Because we do not schedule several patients at the same time, all appointments are reserved exclusively for you. In return, we ask that you make every effort not to change your reserved dental appointment.

I understand that my co-insurance is due at time of service, or I must abide by the payment arrangements set up prior to treatment. I understand that after 60 days, any unpaid balance will incur a $10 billing fee. I understand that failure to pay amounts due to this office will result in my account being placed with a collection agency. In the event that my account is further referred to an attorney, I agree to pay all collection and attorney fees.

Date: _____ Signature: _____

Signature of patient/parent/legal guardian

## Minor/Child Consent

I, being the parent or legal guardian of _____, do here, by request and authorize the dental staff to perform necessary services for my child, including but not limited to radiographs (x-rays) and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered. I also understand that the parent or guardian who brings my child in for treatment will be responsible for payment. A receipt will be provided so I may seek reimbursement.

Date: _____ Signature: _____

Signature of patient/parent/legal guardian