Dental Excellence, PC

PATIENT REGISTRATION

Date_____

Patient Name_____
Last First Middle Initial Name Called By

Address_____Telephone #_____

City_____ State_____ Zip _____ Social Security #_____-____-_____

Email _____ Sex: Male___ Female ___Birthday ___/___/___

Single___ Married___ Widowed___ Separated___ Divorced___

Employed By_____ Occupation_____

Business Address_____

City_____ State_____ Zip_____ Telephone_____

Spouse Name _____Birthday ___/___/___ Social Security # _____-_____-_____

Employer _____Business Address _____

City _____ State _____ Zip _____ Telephone # _____

Who is responsible for this account? _____Relationship to the patient _____

Emergency Contact and Phone Number_____

If you are a new patient, whom may we thank for referring you? _____

Dental Insurance Primary Carrier
Insured's Name Social Security #

_____
Insurance Company

_____
Group Number ID Number Birthdate

_____
Insured's Employer

_____

Dental Insurance Secondary Carrier
Insured's Name Social Security #

_____
Insurance Company

_____
Group Number ID Number Birthdate

_____
Insured's Employer

_____

AUTHORIZATION AND RELEASE

KINDLY GIVE TWO BUSINESS DAYS NOTICE TO AVOID A BROKEN APPOINTMENT FEE IF UNABLE TO KEEP APPOINTMENT.

In the event that your account is placed with a Collection Agency, a collection fee in the amount of 30% of the then outstanding balance may be added to your account and shall become a part of the Total Amount Due. You will be responsible for any and all cost of collection, including attorney fees and court cost.

You agree, that in order for us to service your account or to collect any amounts you may owe, we and our collection agencies may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers. We and our collection agencies may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

Signature of Patient or Parent of Minor Date

_____

Dental Excellence, P.C.

atient Name _____ Birth Date_____

ental History

_____

_____

Is there anything about having dental treatment you would like us to know? _____

_____

_____

Do you have any dental problems right now? YES ☐ NO ☐ If yes, _____

_____

Do you have any drug allergies or have you ever had an adverse reaction to medication or substance? YES ☐ NO ☐ If yes, _____

_____

ave you ever responded adversely to medical or dental atment? YES ☐ NO ☐ If yes, _____

_____

Snore or wear a CPAP?	☐	
Clench or grind your teeth while awake or asleep?	☐	
Bite your lips or cheeks regularly?	☐	
Hold foreign objects with your teeth? (pencils, pins, fingernails, etc.)	☐	
Mouth breathe while awake?	☐	
Have tired jaws, especially in the morning?	☐	
Smoke/Chew tobacco? If so, how much?	☐	If yes _____
Orthodontic treatment?	☐	
Oral surgery?	☐	
Periodontal treatment?	☐	
Your teeth ground or bite adjustment?	☐	
A bite plate or mouth guard?	☐	
A serious injury to the mouth or head?	☐	If yes _____
Sensitive to hot and cold?	☐	If yes _____
Sensitive to sweets?	☐	
Sensitive to biting or chewing?	☐	
Have you noticed any mouth odors or bad tastes?	☐	
Do you frequently get cold sores. blisters or any other oral lesions?	☐	
Do you gums bleed or hurt?	☐	
Have your parents experienced gum disease or tooth loss?	☐	
Have you noticed any loose teeth or a change in your bite?	☐	
Do you have difficulty in chewing on either side of the mouth?	☐	
Does food tend to become caught between your teeth?	☐	If yes _____
Clicking or popping of the jaw?	☐	
Pain? (joint, ear, side or face)	☐	If yes _____
Difficulty in opening or closing mouth?	☐	
Headaches, neckaches or shoulder aches?	☐	
Sore muscles? (neck or shoulders)	☐	
Are you satisfied with your teeth's appearance?	☐	
Would you like to keep all of your teeth all of your life?	☐	
Do you feel nervous about having dental treatment?	☐	If yes _____
Have you ever had an upsetting dental experience?	☐	If yes _____

Dental Excellence, P.C.

Emergency Contact _____

Pharmacy Contact _____

Are you under a physician's care now?	☐ YES	☐ NO	If yes _____
Have you been hospitalized or had a major operation?	☐ YES	☐ NO	If yes _____
Have you ever had a serious head or neck injury?	☐ YES	☐ NO	If yes _____
Are you taking any medications, pills or drugs?	☐ YES	☐ NO	If yes _____
Have you ever taken Fosamax, Boniva, Actonel or any medications containing bisphosponates?	☐ YES	☐ NO	If yes _____
Do you use tobacco?	☐ YES	☐ NO	
Do you use controlled substances?	☐ YES	☐ NO	If yes _____

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs
☐ Local Anesthetics

Other ☐ If yes _____

Do you have, or have you had, any of the following? Check all that apply.

☐ AIDS/HIV Positive	☐ Cortisone Medicine	☐ Hepatitis A	☐ Radiation Treatment
☐ Alzheimer's Disease	☐ Diabetes	☐ Hepatitis B or C	☐ Recent Weight Loss
☐ Anaphylaxis	☐ Drug Addiction	☐ Herpes	☐ Renal Dialysis
☐ Anemia	☐ Easily Winded	☐ Rheumatism	☐ Angina
☐ Emphysema	☐ High Blood Pressure	☐ Artificial Heart Valve	☐ Arthritis/Gout
☐ Epilepsy or Seizures	☐ High Cholesterol	☐ Excessive Thirst	☐ Excessive Bleeding
☐ Hives or rash	☐ Artificial Joint	☐ Fainting Spells/Dizziness	☐ Hypoglycemia
☐ Sickle Cell Disease	☐ Asthma	☐ Kidney Problems	☐ Irregular Heartbeat
☐ Sinus Trouble	☐ Blood Disease	☐ Breathing Problems	☐ Blood Transfusion
☐ Leukemia	☐ Stomach/Intestinal Disease	☐ Bruise Easily	☐ Frequent Headaches
☐ Liver Disease	☐ Stroke	☐ Glaucoma	☐ Low Blood Pressure
☐ Swelling of Limbs	☐ Cancer	☐ Mitral Valve Prolapse	☐ Lung Disease
☐ Thyroid Disease	☐ Chemotherapy	☐ Osteoporosis	☐ Tonsillitis
☐ Chest Pains	☐ Heart Attack/Failure	☐ Pain in Jaw Joints	☐ Tuberculosis
☐ Cold Sore/Fever Blisters	☐ Heart Murmur	☐ Parathyroid Disease	☐ Tumors or Growths
☐ Congenital Heart Disorder	☐ Heart Pacemaker	☐ Psychiatric Care	☐ Ulcers
☐ Convulsions	☐ Heart Trouble/Disease		☐ ADHD
☐ Asperger's	☐ COVID-19		

Have you ever had a serious illness not listed above? ☐ YES ☐ NO If yes, _____

Additional Comments: _____

Authorization:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X_____ Date_____

Dental Excellence, PC

PHYSICIANS & MEDICATIONS

Print Patient Name _____ DOB _____

Pharmacy _____ Pharmacy #_____

Please list all treating physicians, including your primary care provider (PCP) and contact info, including: name, address, and phone number.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Please list all medications you are currently taking, including dosage and frequency.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Dental Excellence, PC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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*You may refuse to sign this

I have received a copy of this office's Notice of Privacy Practices.

Print Name_____

Signature_____Date_____

I authorize sharing my information with the following individuals:

Name: _____Relationship:_____

Name: _____Relationship:_____

Name: _____Relationship:_____

Name: _____Relationship:_____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

____ Individual refused to sign
____ Communications barriers prohibited obtaining the acknowledgement
____ An emergency situation prevented us from obtaining acknowledgement
____ Other (Please Specify)_____

Dental Excellence, PC

Appointment Policy

Dental Excellence, PC does require 2 business days notice for any cancellations. Your appointment time has been reserved for you and we strongly encourage all patients to keep their appointments.

A missed dental appointment presents problems for us both. For you, a missed dental appointment causes a delay in treatment that was recommended to help improve your dental health.

For our office, a missed dental appointment prevents us from scheduling another patient that could benefit from treatment. We schedule individual time with each patient to allow us to deliver the quality, personal care that every patient deserves.

Any missed or broken appointment without appropriate notice may be subject to a broken appointment fee.

My signature below indicates my acceptance of these policies.

Patient/Legal Guardian Signature:

_____

Date: _____

Dental Excellence, P. C.

ABOUT DENTAL INSURANCE AND YOUR TREATMENT ESTIMATE

Any treatment estimate given to you is just that, **AN ESTIMATE**. We do our best to be as accurate as possible; however, if you must know exactly what your co-pay will be prior to treatment, please request that we send a pre-determination to your insurance company. Your insurance company may take several weeks to respond, but is the only way to be sure in advance of exactly what your insurance will pay and for which procedures.

Some insurance companies still "downgrade" or give an alternate benefit for certain procedures. This includes but is not limited to: paying bridges as partials, composite or tooth colored restorations as the silver restorations or paying for metal type crowns on posterior teeth. When this happens, we will bill you for any remaining balance after your insurance pays. If this is a concern for you, please request a pre-determination. Our doctors diagnose and recommend the best treatment for your situation. If you need to know if there are other treatment options, please ask your doctor or his clinical staff before they bring you up front to check out. The business office staff is not clinical and does not know what, if any options you may have.

If you have a treatment plan that you have not completed and your insurance changes, please request a new estimate. Our computer software does not automatically update past estimates to reflect new insurance coverage, nor is this something the office staff is able to track.

If you do have a change in dental insurance it is best to let us know **BEFORE** your appointment date as this allows us time to find whether your new insurance covers various services at our office.

Our office does not determine your benefits. Your plan is chosen by your employer. Any questions regarding why your insurance plan does not cover certain treatment should be addressed to your employer.

We are pleased to file your insurance claims as a courtesy for you. We will attempt to help you maximize your benefits, but since we deal with hundreds of insurance companies with many assorted plans, the sole **RESPONSIBILITY** for payment of all dental fees rest with you, the patient. If the insurance payment varies from the anticipated coverage, any balance is your responsibility. In case of overpayment, we will gladly credit your account or refund the difference.

If you have any questions, please ask prior to treatment.

I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THE POLICIES REGARDING INSURANCE AND TREATMENT ESTIMATE

_____ _____

Patient Signature Date