Welcome!

REGISTRATION FORM

Section I: Patient Information **Date**_____

Name:_____ I Prefer to be called: _____
Date of Birth:_____ Social Security Number:_____ ☐ Male ☐ Female
Address:_____City:_____State:_____Zip_____
Phone* (_____)_____ Work Phone* (_____) _____ Cell Phone* (_____)_____
Driver's License _____ Email Address_____
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
***Please note that we need two contact telephone numbers in case of an emergency or inclement weather closing.**

Section II Parent/Guardian Info

Relationship to Patient: ☐ Parent ☐ Other_____
Name: _____ Date of Birth: _____
Address: _____
City: _____ State: _____ Zip: _____ SSN# _____
Email_____ Phone (____) _____Work Phone (____) _____

Section III Insurance Information

Name of Insured_____DOB_____Relationship to Patient _____
SSN#:_____ Name of Employer: _____ Work Phone: (____) _____
Address of Employer: _____City_____State:_____Zip _____
Insurance Company_____ Grp #_____ ID#_____
Ins Co Address: _____ Ins Co. Phone: _____

---------- DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING ----------

Name of Insured_____DOB_____Relationship to Patient _____
SSN#:_____ Name of Employer: _____ Work Phone: (____) _____
Address of Employer: _____City_____State:_____Zip _____
Insurance Company_____ Grp #_____ ID#_____
Ins Co Address: _____ Ins Co. Phone: _____

Section IV Getting to Know You

Why did you select our office? _____
Whom may we thank for referring you: ☐ Phonebook ☐ Sign out Front ☐ Website/Internet ☐ Mail/Flyer
☐ Patient _____ ☐ Other _____
Is another member of your family or relative a patient in our practice? _____
Person to contact in case of emergency_____ Relationship_____
Phone (_____)_____ Work Phone (_____) _____ Cell Phone (_____)_____

APPOINTMENT POLICY

When you make an appointment with us please be on time since we have reserved our time just for you. If you must change an appointment, please provide us with at least a **48 hour notice** so that we may use our time to accommodate other patients. Broken and missed appointments may result in a $65 fee being accessed to your account. All appointments 90 minutes or longer in length will require a $65 deposit, all sedation cases require a deposit equal to the cost of the sedation as the deposit, due at the time of scheduling. The remaining balance will be due at time of service. If you miss or do not give the required notice for your scheduled sedation or 90 minute appointment the deposit will be forfeited and applied to the broken appointment charge, another deposit will be required to reschedule the appointment. If you cancel or fail to show for three (3) or more appointments within a one (1) year period we may terminate our professional relationship with you. Arriving 15 minutes, or more, late to your appointment may result in a broken appointment.

Parents are asked to remain in the waiting room during your child's appointment unless invited into the operatory by the doctor.

FINANCIAL POLICY

Beautiful Smiles Family Dental Center's goal is to provide quality dental care services to our community while keeping costs under control. In order to meet this goal, we need the help of all our patients.

Co-Payments/Insurance:

If you have dental insurance, our office staff will assist you by submitting insurance forms and verifying the coverage that your particular insurance plan provides. You are responsible for any applicable deductible amounts and the estimated portion that your insurance does not cover, **on or before** your scheduled appointment unless other financial arrangements have **previously** been made with the Office Manager. Please be advised that although our office will make every effort to accurately ***estimate*** what your insurance will pay, this ***does not, in any way***, guarantee actual payment from your insurance company. You will be financially responsible for the account, should your insurance plan(s) not honor financial benefits for any procedure(s).

Uninsured patients will be responsible for payment on all services rendered by our office at the time of their appointment.

Payment Options and Finance Charges/Fees:

For your convenience we accept Cash, Check, Visa, MasterCard, & Discover. We also offer Care Credit financing –a program that offers interest free options. No post-dated checks will be accepted nor can we accept personal checks at your first appointment with us.

Balances in excess of 30 days are subject to a finance charge of 1.5% per month (18% annual). Balances in excess of 60 days will be considered delinquent. Returned checks are subject to a $35 accounting fee. After hours/weekend visits will result in a $150 fee for existing patients and $250 fee for new patients.

AUTHORIZATION AND CONSENT

I acknowledge that I have read and understand the preceding policies and that I have been offered a copy of the policy. I agree to pay for all services rendered by this office. I authorize and request my insurance company to pay my benefits directly to BSFDC. I also understand that should my account become delinquent, my information may be released to a third party collection agency to assist with collecting fees associated with treatment rendered at this office and that I will be responsible for any expenses associated with such action.

I agree and consent to a dental examination by Dr. Graver or Associate Doctor. I understand that additional diagnostic procedures and dental treatments may be recommended and will be discussed with me prior to being done. Also, I acknowledge that there are no guarantees, expressed or implied, as to the results of any procedures or dental treatments performed. I also, authorize BSFDC to release any information regarding my medical/dental history, diagnosis or treatment to third party payers and/or other health professionals.

Print Patient/Guarantor/Responsible Party Name: _____

Signature Patient/Guarantor/Responsible Party: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have been informed of the office's Privacy
(Print Patient's Name)
Practices and Patient Bill of Rights and received a copy. Whom may we speak with on the patient's behalf? _____

_____(You may list more than one name).

_____
(Printed Name-Patient/Parent/Guardian)

_____
(Signature-Patient/Parent/Guardian)

_____
(Date)

_____
(Expiration Date)

At any time the above listed Patient (if of legal age)/Parent/Guardian has the right to revoke his/her consent to release protected information. A written, signed, and dated notice revoking the authorization needs to be submitted to this office.

Messages:
I give my consent to the physicians and staff of Beautiful Smiles Family Dental Center to leave detailed messages or discuss scheduling, treatment/finances, surgery, or other information regarding my care, account, or insurance as follows:

____ On voicemail at home
____ On voicemail at work
____ Cell phone
____ E-mail
____ I do not consent to detailed messages being left at my home, work, email, or cell phone.

_____
Signature of Patient/Parent/Guardian Date

You may refuse to sign this acknowledgement

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 acknowledgment
____ An emergency situation prevented us from obtaining acknowledgment
____ Other (please specify)

BP:_____

HR:_____

Staff Initals:_____

Medical/Dental History

Medical History

How would you rate your overall health? □ Good □ Fair □ Poor

Do you see a physician on a routine basis?_____

When did you last see a physician? _____

Date of last physical examination: _____

Physician Information: _____

Name Phone Number

_____

Address City State Zip

Have you had any illness, operations, or been hospitalized within the past 5 years? □ Yes □ No

If yes, for what reason? _____

Have you had any cosmetic procedures or elective surgeries completed? □ Yes □ No

If yes, please describe: _____

Please provide us with the following information of the physician in charge of the procedure:

_____

Name Phone Number Address City State Zip

Have you had medical x-rays in the last 5 years? □ Yes □ No

If yes, please explain: _____

Are you taking any prescribed medications, over-the-counter medications, creams, supplements or herbs? If yes, please list all □ Yes □ No

Do you take aspirin on a daily basis? □ Yes □ No

	Name	Dose/Frequency	Reason for Taking
Prescribed Medications			
Over the Counter Medications (aspirin?)			
Vitamins, Natural or Herbal Preparations, Diet Supplements			

Have you been told that you needed to be pre-medicated prior to any dental work? □ Yes □ No

If yes, for what reason? _____

Do you use tobacco products? □ Yes □ No

If yes, how interested are you in quitting? □ Very □ Somewhat □ Not Interested

Do you drink alcoholic beverages? □ Yes □ No

If yes, please list how many per week, e.g. 1-2 drinks/week: _____

Do you use recreational or street drugs? □ Yes □ No

If yes, how often? _____

For women:

Are you pregnant? □ Yes □ No

Are you looking to become pregnant? □ Yes □ No

Are you nursing? □ Yes □ No

Are you using a contraceptive? □ Yes □ No

If yes, please read and initial

I understand that taking antibiotics may render contraceptives ineffective. ____

Print Patient's Name: _____

Check any of the following <u>cardiovascular/heart</u> conditions you currently have or have had in the past:

□ Angina □ Arteriosclerosis □ Artificial heart valves
□ Chest pain upon exertion □ Congenital heart lesions/defects □ Congenital heart failure
□ Coronary artery disease □Damaged heart valves □ Heart attack
□ Heart murmur □ Heart surgery □ High blood pressure
□ Irregular heartbeat □ Low blood pressure □ Mitral valve prolapsed
□ Heart pacemaker □ Rheumatic heart disease/Rheumatic fever □ Scarlet fever
□ Stroke □ Other (please specify): _____
□ **NONE**

Check any of the following <u>respiratory conditions</u> you currently have or have had in the past:

□ Asthma □ Bronchitis □ Emphysema
□ Hay Fever □ Persistent cough or cough that produces blood □ Shortness of breath
□ Sinus problems □ Tuberculosis (TB) □ Other (please specify): _____
□ **NONE**

Check any of the following <u>blood disorders</u> you currently have or have had in the past:

□ Abnormal bleeding □ Anemia □ Blood Transfusion □ Bruise easily
□ Hemophilia □ Excessive bleeding □ Leukemia
□ Sickle cell disease □ Other (please specify): _____
□**NONE**

Check any of the following <u>psychological conditions</u> you currently have or have had in the past:

□ Anxiety □ Depression □ Psychiatric treatment □ Nervousness
□ **NONE** □ Other (please specify): _____

Check any of the following <u>liver conditions</u> that you currently have or have had in the past:

□ Cirrhosis/liver disease □ Hepatitis □ Jaundice/yellow jaundice □ Other (please specify): _____
□ **NONE**

Check any of the following <u>health conditions</u> you currently have or have had in the past:

□ Allergies or hives □Arthritis □ Artificial joint □ Cancer
□ Chemotherapy □ Cold sores/fever blisters □ Cortisone medication □ Drug addiction
□ Epilepsy or seizures □ Diabetes □ Fainting or dizzy spells □ Glaucoma
□ Herpes □ HIV antibody or AIDS □ Kidney disease/dialysis □ Irritable bowel
□ Measles □ Mumps □ Radiation treatment □ Rheumatism
□ Tumor □ Sexually transmitted disease □ Stomach problems □ Thyroid disease
□ Ulcers
□ **NONE**

Do you have any allergies (ie itching, rash, swelling of hands, eyes, or feet) or are you made sick by metals, jewelry, latex rubber, aspirin, penicillin, codeine, or any drugs, foods, or medications? □ Yes □ No

If yes, please list what you are allergic to and your reaction: _____

_____

Do you have any disease, condition, or problem that was not previously listed? □ Yes □ No

If yes, please describe here: _____

When you walk up stairs or take a walk, do you ever have to stop because of chest pain? □ Yes □ No
Do your ankles swell during the day? □ Yes □ No
Do you need 2 or more pillows under your head or shoulders to sleep? □ Yes □ No
Do you wake up short of breath? □ Yes □ No
Have you lost or gained more than 10 pounds in the last year? □ Yes □ No
Are you on a special diet? □ Yes □ No

To the best of my knowledge all of the preceding "Patient Information" and health history answers are true and correct. I also understand that it is my responsibility to inform the office of any changes to my medical history prior to **all** appointments.

Print Patient's Name: _____

Dental Needs Survey

Date of your last dental appointment? _____
Why did you leave your last dentist? _____
How often do you brush your teeth? _____
How often do you floss your teeth? _____
What type of oral hygiene tools do you use? _____
Do your gums bleed at any time? □ Yes □ No
Do you have aching or sensitive teeth? □ Yes □ No
Have you ever had an injury to your face or jaw? □ Yes □ No
Do you presently have or have you had *pain or discomfort* in the mouth, face, jaws or jaw joints (TMJs)? □ Yes □ No
Have you had trouble with any previous dental treatment? □ Yes □ No

Please rate on a scale of 1 to 5 the importance of each of the following regarding your dental care (the most important would be #1)

_____ Preventive Dental Health Care
_____ Excellence & Quality of Service
_____ Other _____
_____ Freedom From Pain
_____ Cost & Affordability

Please rate, as above, what a dentist has to do to gain your confidence:

_____ Show me what he/she is doing or needs to do so I can clearly understand what is happening.
_____ Listen to my concerns and explain thoroughly the procedures to be performed.
_____ Make sure I feel comfortable and informed at all times.

Please check the level of fear you have about your dental visits (10 being the greatest fear)

□1 □2 □3 □4 □5 □6 □7 □8 □9 □10

Are you concerned about the following (yes or no)?

_____ Existing discomfort
_____ Replacing old mercury silver fillings?
_____ Recurring or untreated gum disease?
_____ Mouth odor?
_____ Whitening your teeth?
_____ Appearance of your smile?
_____ Prevention of decay?
_____ Other: _____

Please check one

When discussing my treatment plan, I prefer:
□ The Big Picture □ Detail by Detail
When evaluating my smile, it's most important:
□ What I See □ What Others See
Do you have dental insurance: □ Yes □ No
If you did not have dental insurance, would you still have your dental care completed? □ Yes □No

Print Patient Name: _____

Revised February 12, 2018

Parental Consent Form

Consent to Parental Absence in Dental Operatory During Dental Treatment/Cleanings

I _____ understand that prior to any treatment being
Print Full Name of Parent/Legal Guardian

performed on my child, all my questions and concerns will be answered. I will have the opportunity to walk my child to the assigned operatory and be present during the initial set-up of the planned procedure. Once it is time for treatment to begin, I will then be required to wait in the waiting room. I understand the need for the providing dentist/hygienist to have a space clear of distraction in order to provide safe and efficient treatment to my child. I understand this consent is binding and will **ONLY** be revised if the request is made by me during the scheduling of my child's appointment; no same day requests will be granted. Furthermore, I understand that all pediatric patients will be scheduled in the morning due to better behavior and cooperativeness seen typically during this time of day.

_____ _____

Parent/Legal Guardian Signature Date