Patient Registration

Today's Date _____

Patient's Name _____ Birth Date _____ Sex ❑ M ❑ F

Patient's Address _____ Home No. _____

City _____ State _____ Zip _____ Cell No. _____

Patient's Employer _____ Position Held _____ Work No. _____

Soc. Sec. No. _____ Marital Status ❑ Single ❑ Married ❑ Legally Separated

Name of Spouse / Parents _____ E-mail Address _____

Spouse / Parents Home No. _____ Work No. _____ Cell No. _____

Whom may we thank for referring you _____

Nearest neighbor or relative's name, address and phone No. _____

(Not living with you) _____

In case of emergency, whom may we contact? _____ Relation _____ Phone No. _____

Person Responsible For This Account Other Than Above Named Patient

Responsible Party's Name _____ Birth Date _____ Sex ❑ M ❑ F

Street Address (If Different Than Above) _____

City _____ State _____ Zip _____ Phone No. _____

Responsible Party's Employer _____ Soc. Sec. No. _____

_____ Work Phone No. _____

Dental History

1. Are you having any dental problems at this time? _____

   _____

2. How long has it been since you have been to a dentist for treatment? _____

   For dental cleaning and examination? _____

3. Does your previous dentist have a full mouth or panoral series of X-Rays? _____

   Name and address of the previous dentist _____

4. Are your teeth sensitive to ❑ Hot ❑ Cold ❑ Sweets ❑ Biting Pressure ❑ Without Provocation

   ❑ Not Sensitive _____

5. Have you had your teeth straightened? _____ Are you happy with the results? _____

6. How often do you brush your teeth? _____ ❑ Soft ❑ Medium or ❑ Hard Bristle Brush

7. Do you use floss? _____ If so, how often? _____

8. Do your gums bleed? _____

9. Have you had gum surgery? _____ If so, when?

10. Does your food frequently stick between your teeth in any particular spot? _____

11. Do you grind or clench your teeth? _____

12. Have you had aching or pain in your jaws or around your ears, and, or clicking noises when you chew or talk? _____

    _____

13. Have you had injections of local anesthetic (Novacaine) to numb your teeth? _____ Problems with? _____

14. Have you had Nitrous Oxide ("Laughing" or "Sweet") gas in a dental office? _____ Problems with? _____

    Preferences _____

15. Does anything in particular bother you about coming to the dentist? _____

    _____

16. Have you ever been dissatisfied with the dental care you have received? _____

    If so, why? _____

    _____

Medical History

1. Have you been a patient in a hospital during the past two years? ❑ Yes ❑ No

2. Have you been under the care of a medical doctor during the past two years? ❑ Yes ❑ No

3. Are you taking any medicine, drugs or birth control? ❑ Yes ❑ No

4. Are you allergic to any medications or have any sensitivities? ❑ Yes ❑ No

5. Has a physician ever recommended you to take antibiotics prior to dental care? ❑ Yes ❑ No

6. Check any of the following which you have had or have at the present

❑ Heart Disease or Attack	❑ Emphysema / Asthma	❑ Hepatitis A or B
❑ Chest Pains	❑ Persistent Cough	❑ Liver Disease
❑ High Blood Pressure	❑ Tuberculosis (TB)	❑ Drug Addiction
❑ Heart Murmur	❑ Other Respitory Problems	❑ Blood / Bleeding Problems
❑ Rheumatic Fever	❑ Sinus Trouble	❑ Bruise Easily
❑ Scarlet Fever	❑ Venereal Disease (Syphilis, Gonorrhea)	❑ Diabetes
❑ Artificial Valves / Joints	❑ Thyroid Disease	❑ Genital Herpes
❑ Heart Pacemaker	❑ X-Ray or Cobalt Treatment	❑ Epilepsy or Seizures
❑ Heart Surgery	❑ Chemotherapy (Cancer, Leukemia)	❑ Fainting or Dizzy Spells
❑ Anemia	❑ Arthritis / Rheumatism	❑ Nervousness
❑ Stroke	❑ AIDS / HIV Infection	❑ Psychiatric Treatment
❑ Kidney Trouble	❑ Cancer	❑ None of These Apply to Me

7. Do you have any disease, condition or problem not listed? ❑ Yes ❑ No

Name of Physician _____ Phone No. _____

8. WOMEN: Are pregnant now? ❑ Yes ❑ No If so, Due Date _____

Name of Physician _____ Phone No. _____

My greatest concern about my dental care is (Check):

❑ Appearance	❑ Expense	❑ Function
❑ Pain	❑ Convenience	❑ Health

Other: _____

Payment Policy

We will make every effort to keep the cost of your dental care down.

We will **ESTIMATE** your fees at the time of your consultation, based on information your insurance company has given us, but please remember that all quotes are subject to insurance company ceilings in amounts they determine. All insurance companies set their own ceilings, just as we set our own fees. We pattern our fees after regional averages.

PAYMENT OF YOUR PORTION, AS WE HAVE ESTIMATED, IS DUE AT THE TIME OF SERVICE. Any portion not paid for by your insurance company is your responsibility, and is due upon receipt of our statement. Any unpaid balance is subject to a finance charge of 1.5% per month or 18% per year. Any attorney or collection fees incurred due to delinquency in payment will also be charged to the patient.

_____

WE DO NOT ACCEPT MONTHLY PAYMENT PLANS.

For your convenience, we accept the following methods of payment:

1. Cash, Check, or Money Order
2. Visa, MasterCard, Discover, and American Express
3. Loans may be available through American General Finance at no interest for one year

Our entire team will make every effort to see you at your appointed time, so we appreciate your arriving on time. Appointment times are reserved expressly for you. If you cannot make your scheduled time, we require a 24-hour notice to cancel the appointment and avoid possible broken appointment charges. (Broken appointment charges are a minimum of $50 for a broken Hygiene Appointment and $50 per 1/2 hour of time broken with the doctor).

Agreement

I consent to having Dr. Shahamat, her associates or her staff request information and / or X-Rays from my previous dentist and physician as necessary to better care for my oral health.

❑ I have no dental coverage

❑ I have dental insurance through: ❑ My Employer ❑ My Spouse's Employer ❑ My Mother's Insurance ❑ My Father's Insurance

❑ I am between the ages of 19 and 23, and covered by my parents' insurance. I am a full-time student at _____ . I expect to graduate in _____ .

I understand that the doctor's staff has communicated with my insurance company and have been given some basic information about my insurance policy, but in no way expect them to know all the possible exceptions that may be attached to my particular policy. I further understand that all quotes regarding insurance payment of service will be ESTIMATES. I am ultimately responsible for knowing my policy and paying any differences my insurance company does not cover. Any dispute over insurance payment is my responsibility to resolve with my insurance company.

I have read and understand the payment policies of this office.

I agree to the above policies _____

Update of Patient Information

Patient ____

Date ______________ New Marital Status ☐ Married ☐ Divorced (Name Changed to ______________)

New Address ____

New Phone No. ______________ New Employer ______________ New Work No. ______________

New Insurance Company ____________________ New Insurance Phone ____________________

Changes in Medical History ____

Changes in Medications or Allergies ____

Changes in Full-time Student Status (If between 19 and 23, covered by parents' insurance)

Attending what school ____________________ Graduating ____________________

☐ No Changes in My History Patient / Guardian's Signature ____________________

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