Patient Registration Form

American Dental Association
www.ada.org

Email: Today's Date:

Preferred Name: ❑ Miss ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. Referred by:

Name: Last First Middle Home Phone: *Include area code* ( ) Cell Phone: *Include area code* ( )

Address: Mailing address City: State: Zip:

SS#: Date of Birth: Sex: M F

Employer: Business Phone: *Include area code* ( )

Emergency Contact: Relationship: Home Phone: *Include area code* ( ) Cell Phone: *Include area code* ( )

College Student Status: ❑ Full Time ❑ Part Time Please provide school info: School Name:

Employment Status: ❑ Full Time ❑ Part Time ❑ Retired Address:

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed Address 2:

Pref. Pharmacy: Phone: ( ) City, State, Zip:

Dental Insurance Information

Primary Insurance Information

Name of Insured: Relationship to Patient: ❑ Self ❑ Spouse ❑ Child ❑ Other

Insured Soc. Sec.: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

ID#: Gr#:

Secondary Insurance Information

Name of Insured: Relationship to Patient: ❑ Self ❑ Spouse ❑ Child ❑ Other

Insured Soc. Sec.: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

ID#: Gr#:

Dental Information For the following questions, mark (X) your responses to the following questions.

	Yes	No	DK
Do your gums bleed when you brush or floss?	❑	❑	❑
Are your teeth sensitive to cold, hot, sweets or pressure?	❑	❑	❑
Is your mouth dry?	❑	❑	❑
Have you had any periodontal (gum) treatments?	❑	❑	❑
Have you ever had orthodontic (braces) treatments?	❑	❑	❑
Have you had any problems associated with previous dental treatment?	❑	❑	❑
Is your home water supply fluoridated?	❑	❑	❑
Do you drink bottled or filtered water?	❑	❑	❑
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY			
Are you currently experiencing dental pain or discomfort?	❑	❑	❑

	Yes	No	DK
Do you have earaches or neck pains?	❑	❑	❑
Do you have any clicking, popping or discomfort in the jaw?	❑	❑	❑
Do you brux or grind your teeth?	❑	❑	❑
Do you have sores or ulcers in your mouth?	❑	❑	❑
Do you wear dentures or partials?	❑	❑	❑
Do you participate in active recreational activities?	❑	❑	❑
Have you ever had a serious injury to your head or mouth?	❑	❑	❑

Date of your last dental exam:
What was done at that time?

Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

over

Medical Information

Please mark (X) your responses to indicate if you have or have not had any of the following diseases or problems.

(Check DK if you Don't Know the answer to the question)	Yes	No	DK
Are you now under the care of a physician?	☐	☐	☐
Physician Name: _____			
Phone: *include area code* (____) _____			
Address/City/State/Zip: _____			
_____			
Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐
If yes, what condition was treated? _____			
_____			
Date of last physical exam: _____			
Do you wear contact lenses?	☐	☐	☐
Are you taking, or have you taken, any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine) or fen-phen (fenfluramine-phentermine combination)?	☐	☐	☐
Are you taking or scheduled to begin taking either of the medications alendrontate (Fosamax®) or risendronate (Actonel®) for osteoporosis or Paget's disease?	☐	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastic cancer?	☐	☐	☐
Date Treatment Began: _____			

	Yes	No	DK
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐
If yes, what was the illness or problem? _____			
Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐
If so, please list all, including vitamins, natural or herbal preparations and/ or diet supplements: _____			
_____			
_____			
Do you use controlled substances (drugs)?	☐	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)?	☐	☐	☐
If so, how interested are you in stopping? Circle one: VERY / SOMEWHAT / NOT INTERESTED			
Do you drink alcoholic beverages?	☐	☐	☐
If yes, how much alcohol did you drink in the last 24 hours? _____			
If yes, how much do you typically drink in a week? _____			
WOMEN ONLY Are you:			
Pregnant?	☐	☐	☐
Number of weeks: _____			
Taking birth control pills or hormone replacement?	☐	☐	☐
Nursing?	☐	☐	☐

Joint Replacement. Have you had an orthopedic total joint replacement (hip, knee, elbow, finger)? ☐ ☐ ☐

Date: _____ If yes, have you had any complications?

Allergies - Are you allergic to, or have you had a reaction to: To all **yes** responses, specify type of reaction.

	Yes	No	DK
Local anesthetics _____	☐	☐	☐
Aspirin _____	☐	☐	☐
Penicillin or other antibiotics _____	☐	☐	☐
Barbituates, sedatives, or sleeping pills _____	☐	☐	☐
Sulfa drugs _____	☐	☐	☐
Codeine or other narcotics _____	☐	☐	☐
Metals _____	☐	☐	☐
Latex (rubber) _____	☐	☐	☐
Iodine _____	☐	☐	☐
Hay fever / seasonal _____	☐	☐	☐
Animals _____	☐	☐	☐
Food _____	☐	☐	☐
Other _____	☐	☐	☐

	Yes	No	DK
Heart murmur	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Artificial heart valves	☐	☐	☐
Rheumatic fever	☐	☐	☐
Cardiovascular disease	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Coronary artery disease	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Congenital heart defects	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, date: _____			
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/ Radiation treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/Persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐
Glaucoma	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders	☐	☐	☐
If yes, specify: _____			
Sleep disorder	☐	☐	☐
Mental health disorders	☐	☐	☐
If yes, specify: _____			
Recurrent infections	☐	☐	☐
Type of infection: _____			
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/ Migraines	☐	☐	☐
Severe of rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ☐ ☐ ☐

Name of physician or dentist making recommendation: _____ Phone: (____) _____

Do you have any disease, condition, or problem not listed above that you think I should know about? ☐ ☐ ☐

Please explain: _____

NOTE: Both Doctor and patient are encouraged to discuss any and all relevent patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will reyl on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: _____ Date: _____

Please Read and Sign at the bottom, acknowledging that you were informed of these policies.

Let us know if you have any questions about our Office Policies. Thank You

Office Policy

Financial Policy

Thankyou for choosing ALOHA DENTAL to serve your dental care needs. We provide High-Quality dental care to our patients and are committed to your treatment being successful. Please understand that your financial obligation is considered a part of your treatment. In the interest of good dental care practice, it is desirable to establish a credit policy to avoid misunderstandings, to assist our patients, we offer the following methods for taking care of their account in our office.

- On your first visit we expect you to supply our office with your insurance information and photo ID. If any changes occur during the time you are a patient, it is your responsibility to inform the office with any changes. Our office will not be responsible for claims submitted o insurance companies by which you are no longer covered.
- New patients are required to pay for services in full on their first visit. If the patient is a member of the HMO/DMO plan, then the co-payment is due. Patients are required to pay their deductible and co-payments are at the time of each visit.
- While we accept most insurance plans and are happy to aid in submission of your claims, it is your responsibility to read your policy and be aware of the services that are covered and not covered by your individual plan.
- As a courtesy, we will gladly bill your insurance when you provide us with the current information and necessary forms. Often, we can contact your insurance provider prior to appointment and estimate a portion of the bill. We ask that either you pay your portion of the bill at the time of service, or that a suitable written financial written agreement be reached at the time of service. Even though you might have an insurance claim pending. You will receive a receive a monthly statement for the outstanding balance on your account until it is paid in full. We cannot accept responsibility for collecting an insurance claim after 60 days or for negotiating a disputed claim. Insurance policies are a contract between you, your employer and the insurance carrier. Please be aware that some, and perhaps all of the services rendered may not be covered under your individual insurance policy. You are ultimately responsible for payment of your account.
- If not, payment is received on an account after two monthly statements our office will make every effort to contact the responsible party. If the party responsible cannot be reached, a third bill will be sent indicating *"this will be the final notice for payment".* If the party fails to contact the office after receiving such notice, the account will be sent to a collection agency.
- Financial options are available to all patients. Please feel free to ask one of our office personnel.

New, Failed and /or Cancelled Appointment

- We value each of our patient's time, which we book our schedule accordingly. We cannot guarantee same day treatment.

- if an appointment has been reserved for you, we kindly ask that patients give us a 24-hour notice for cancellations; otherwise, we reserve the right to charge a minimum of $30.00 per half hour, which is currently our broken appointment fee. If the appointment is with a specialist, the minimum fee is $50.00 per half hour visits. The length of the time reserved and the number of prior failed appointments determines your charge. We will not offer appointments to patients who fail to show for multiple appointments without having a proper notice.

Estimates and Fees

- After x-rays and examination, you are entitled to and should ask for an estimate of fees to cover your treatment. All estimates are based upon conditions viewed at the time of diagnosis; unforeseen circumstances, such as pulpal therapy or cracked teeth could alter an estimated fee. It is customary to pay for dental services when they are rendered. There is a service charge on all unpaid accounts.
- Delinquent accounts will be turned over to the Credit Reporting Collection Agency.

Notice of Privacy Practices (HIPPA)

- A Laminated copy of our office Notice of Privacy Practices (HIPAA) is available in our office. You have the right to read our notice of Privacy Practices before you decide to sign this consent. Our Notice provides a description of our treatment, payment activities and healthcare operations. Of the uses and disclosures, we make of your protected health information and of other important matters about your protected health information. We encourage you to read it carefully and completely before signing this consent. Upon request we will gladly provide you with your own personal copy of our Privacy Policies.

SIGNATURE: _____ DATE: _____

Authorization for Signature on File

Release of Information/Financial Responsibility/ Authorization for Payment

I (Name of Patient) _____ and/or (name of insured) _____

Herby authorize ALOHA DENTAL to affix my name to any and all claims and/or documents as related to any and all health benefits due from my dependents and I through my employment with (employer name) _____. I herby authorize payment of dental benefits otherwise payable to me directly to the ALOHA DENTAL. I have reviewed the treatment plans and fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefits plan, unless the treating dentist or dental practice have a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to the dental claim.

Signature of Patient (Parent or Guardian if a minor): _____

Signature of Insured: _____ Date: _____