Dental Registration and Health History

Patients Name_____ Social Security No._____

Birthdate_____ Age____ Sex____ Drivers License_____

Mailing Address_____

City_____ State_____ Zip_____

Home Phone _____

Cell Phone _____Email _____

Please ck (√) one: □ Single □ Married □ Divorced □ Widowed

Referred to our office by_____

Have you or any member of your family been seen by us before? □Yes □No

If yes, which family members_____

Emergency contact *other* than Spouse_____Phone ( ) _____ ____

Previous Dentist_____ City_____ Last seen_____

Employment

□ I do not work, I am a full time student I attend: _____

Employer_____ Position_____

Employer's Address_____ City_____

Work Phone ( ) _____ Work Hours (shift) _____

Spouse or Domestic Partner

Spouse's Name_____ Social Security No._____

Birthdate_____

Employer_____ Position _____

Employer's City _____ Phone ( ) _____

Insurance

Primary Insurance_____	Second Insurance _____
Group Number _____ or Local _____	Group Number _____ or Local_____
Policy holder's name_____	Policy Holder's Name_____
Insurance Phone _____	Insurance Phone_____

Dr. Lee Freeman DDS
Patient Consent to Treatment

NOTICE OF PRIVACY PRACTICES, ACKNOWLEDGEMENT (HIPPA):

We keep a record of your personal information and the dental care we provide to you. We use this information in order to provide you with patient care. We may use your phone number, e-mail or a post card to contact you regarding your treatment or appointment. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or obtain a summary of your chart (duplication fee depends on length of summary) by contacting our office Manager. Initial: _____

DRUGS, MEDICATIONS AND ANESTHESIA:

I understand that antibiotics, analgesics and other medications may cause adverse reactions, some of which are, but not limited to redness and swelling of tissues, pain, itching, vomiting and dizziness. I understand that medications, drugs and anesthetics may cause drowsiness and lack of coordination, which can be increased by the use of alcohol or other drugs. I understand that rarely, upon injection of a local anesthetic, I may have prolonged persistent anesthesia, numbness and/or irritation to the area of the injection. I understand that if I select to utilize Nitrous Oxide the possible risks include, but are not limited to, loss of consciousness, obstruction of airway, anaphylactic shock and cardiac arrest. FEMALES: I understand that while on birth control pills, if I am given antibiotics, I should use an alternative way of birth control. Antibiotics suppress the effects of birth control pills. Initial: _____

INSURANCE BENEFITS AND PAYMENTS:

If you are covered by insurance and bring the necessary information that enables us to confirm eligibility and benefits, we will be happy to bill them for your services. Upon request, an estimate will be given to me in writing, on the understanding that it is but a guideline of my treatment costs until final payment is received from your insurance company and your exact share of the bill is known. I authorize and request my insurance company to pay directly to the dentist. I understand that my dental insurance carrier may pay less than estimated and there is no guarantee of benefits from my insurance company to the dentist until a claim is received and processed for payment. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that the insurance company can deny payment on services rendered at any time and I will be responsible to pay the entire balance on my account. A $10.00 fee may be applied for late payments if I have a monthly statement.

Initial: _____

PAYMENT OPTIOINS

In order to keep our fees to you as low as possible, we ask that the payment be made for your rendered services at the time of treatment. For your convenience, we provide a variety of payment options to help you receive the quality of care you need to enjoy a healthy and confident smile. Please identify which form of payment is most convenient for you at the time of service.

CASH/CHECK _____ VISA/MASTERCARD _____

CHANGE IN TREATMENT PLAN:

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth. The most common being, additional tooth surfaces or additional caries discovered while working on the planned treatment. Occasionally, we may need to do root canal therapy following routine restorative procedures due to the cavity being larger and deeper than anticipated. I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results.

Initial: _____

APPOINTMENTS:

We ask that you be on time for your scheduled dental appointments and if it is necessary for you to change an appointment, that you give us at least 24 hours notice so that we are able to accommodate someone else in your reserved chair time. **Our office policy is to charge $75.00 and up for missed appointments.**

Initial: _____

QUESTIONS:

Questions you may have regarding your billing or treatment need to be brought to our attention immediately. It is in our policy to provide you with exceptional service, and would like to be informed if you feel that we are not doing an adequate job.

Signature: _____ Date:_____