Dental Registration, Insurance and History

Patient Information

Date: ____________________

Patient Name: ____ SS#: _________________________

Address: ____

City: ____ State: _______________________ ZIP: __________________

Email: ____

Home Phone: _________________________ Work Phone: ____________ext. _______ Cell Phone: ______________________

Best time and place to reach you: ____

Sex: ❑ M ❑ F ❑ Other ❑ Prefer not to say Age: __________ Birth date: ___________________

Patient Employer/School: ____

Occupation: ____

Spouse's Name: ____

Birth date: ______________________ SS#: ______________________

Spouse's Employer: ____

Who may we thank for referring you? ____

IN CASE OF EMERGENCY, CONTACT

Name: ____ Relationship: ___________________ Phone: _________________

Dental Insurance

Who is responsible for this account? ____

Relationship to Patient ____

Insurance Co. ____ Group# ______________________

Is patient covered by additional insurance? ❑ Yes ❑ No

Subscriber's Name ____ Birth date _____________ SS# ______________________

Relationship to patient: _______________ Insurance Co: ________________________________ Group# __________________

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with ____

Name of Insurance Company(ies)

and assign directly to Dr. Trevor Greene all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all changes whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits for related services.

____

Signature of Patient, Parent, Guardian or Personal Representative

____

Please print name of Patient, Parent, Guardian or Personal Representative

____________________ ____

Date Relationship to Patient

Dental History

Reason for today's visit: ______________________________

Former Dentist: ______________________________ City/State: ______________________________

Date of last dental visit: ______________________________ Date of last dental x-rays: ______________________________

What do you like about your smile? ______________________________

Is there anything you don't like about your smile? ______________________________

Place a mark on "yes" or "no" to indicate if you have had any of the following:

- Bad Breath ❑ Yes ❑ No
- Bleeding Gums ❑ Yes ❑ No
- Blisters on lips or mouth ❑ Yes ❑ No
- Burning sensation on tongue ❑ Yes ❑ No
- Chew on one side of mouth ❑ Yes ❑ No
- Cigarette, pipe, or cigar smoking ❑ Yes ❑ No
- Clicking or popping jaw ❑ Yes ❑ No
- Dry Mouth ❑ Yes ❑ No
- Fingernail biting ❑ Yes ❑ No
- Food collection between teeth ❑ Yes ❑ No
- Grinding teeth ❑ Yes ❑ No
- Gums swollen or tender ❑ Yes ❑ No
- Jaw pain or tiredness ❑ Yes ❑ No
- Lip or cheek bitting ❑ Yes ❑ No
- Loose teeth or broken filings ❑ Yes ❑ No
- Mouth breathing ❑ Yes ❑ No
- Orthodontic treatment ❑ Yes ❑ No
- Pain around ear ❑ Yes ❑ No
- Periodontal treatment ❑ Yes ❑ No
- Sensitivity to cold ❑ Yes ❑ No
- Sensitivity to heat ❑ Yes ❑ No
- Sensitivity to sweets ❑ Yes ❑ No
- Sensitivity when biting ❑ Yes ❑ No
- Sores, growths, or ulcers in mouth ❑ Yes ❑ No

How often do you floss? ______________________________

How often do you brush? ______________________________

Medical History

Place a mark on "yes" or "no" to indicate if you have had any of the following:

- Acid Reflux ❑ Yes ❑ No
- AIDS/HIV ❑ Yes ❑ No
- Alcohol/Drug Addiction ❑ Yes ❑ No
- Anemia ❑ Yes ❑ No
- Arthritis, Rheumatism ❑ Yes ❑ No
- Artificial Heart Valves ❑ Yes ❑ No
- Artificial Joints ❑ Yes ❑ No
- Asthma ❑ Yes ❑ No
- Back Programs ❑ Yes ❑ No
- Bleeding abnormally with surgery ❑ Yes ❑ No
- Cancer ❑ Yes ❑ No
- Chemotherapy ❑ Yes ❑ No
- Circulatory Problems ❑ Yes ❑ No
- Congenital Heart Lesions ❑ Yes ❑ No
- Cough, persistent or bloody ❑ Yes ❑ No
- Diabetes ❑ Yes ❑ No
- Emphysema ❑ Yes ❑ No
- Epilepsy ❑ Yes ❑ No
- Glaucoma ❑ Yes ❑ No
- Migraines ❑ Yes ❑ No
- Heart Problems ❑ Yes ❑ No
- Hepatitis Type ________ ❑ Yes ❑ No
- Oral Herpes ❑ Yes ❑ No
- High Blood Pressure ❑ Yes ❑ No
- Jaundice ❑ Yes ❑ No
- Kidney Disease ❑ Yes ❑ No
- Liver Disease ❑ Yes ❑ No
- Low Blood Pressure ❑ Yes ❑ No
- Mitral Valve Prolapse ❑ Yes ❑ No
- Implanted Cardiac Device ❑ Yes ❑ No
- Psychiatric Care ❑ Yes ❑ No
- Radiation Treatment ❑ Yes ❑ No
- Respiratory Disease ❑ Yes ❑ No
- Rheumatic Fever ❑ Yes ❑ No
- Scarlet Fever ❑ Yes ❑ No
- Sinus Trouble ❑ Yes ❑ No
- Skin Rash ❑ Yes ❑ No
- Special Diet ❑ Yes ❑ No
- Stroke ❑ Yes ❑ No
- Swollen Neck Glands ❑ Yes ❑ No
- Thyroid Problems ❑ Yes ❑ No
- Tonsillitis ❑ Yes ❑ No
- Tuberculosis ❑ Yes ❑ No
- Tumor or growth on head or neck ❑ Yes ❑ No

WOMEN:

Are you pregnant? ❑ Yes ❑ No Due Date: ________________ Are you nursing? ❑ Yes ❑ No

MEDICATIONS

List any medications you are currently taking:

____

____

____

ALLERGIES

- ❑ Aspirin
- ❑ Codeine
- ❑ Latex
- ❑ Local Anesthetic
- ❑ Penicillin
- ❑ Sulfa
- ❑ Other ______________

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Insurance Policy

Initial that you understand

________ **1.** Your dental benefits are based on a contract between your employer and your insurance company, and Piney Orchard Dental has no say in what your insurance will cover or not cover. Please remember, in most cases, dental insurance will **NOT** pay for the entirety of your dental treatment.

________ **2.** We participate with many PPO dental insurance plans. We estimate your portion of payment based on the most up-to-date information we have, but keep in mind this is an **ESTIMATE**. We would be happy to file a "pretreatment estimate" with your insurance company, but this will delay treatment. These "pretreatment estimates" also do **NOT** guarantee your insurance will cover any treatment.

________ **3.** We will send claims to your insurance as a courtesy. If insurance does not pay in 90 days, Piney Orchard Dental reserves the right to request payment in full for services directly from you. **Ultimately, you are responsible for all charges incurred in our office.**

________ **4.** You are responsible for presenting Piney Orchard Dental with your insurance information at your initial visit and updating your insurance information with any changes.

I agree with the above conditions:

Print Name:_______________________________________ Date:_________________

Patient/Parent Signature:____

Piney Orchard Dental

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

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

____
Please Print Name

____
Signature

____
Date

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)

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Appointment Reminders and How to Avoid Extra Costs

Reminders -

We understand life is busy. To help, we will send you a "save the date" email after you schedule an appointment and confirmation texts 2 weeks, 3 days, and 2 hours prior to your appointment. If you do not confirm via our simple email or text service we will call you 2 days before your appointment.

We reserve time just for you -

When you schedule an appointment we reserve ample time with Dr. Greene and the hygienists *just for you*. Please know we respect your time, and we appreciate you respecting our time in return. When you make an appointment with us, we consider it a confirmation that you will arrive at your appointed time.

Can't make your appointment -

If you do not contact us AT LEAST 48 hours prior to your appointment time to inform us of a necessary cancellation, you will be charged a non-refundable $100 missed appointment fee. This ensures that we can continue our policy of providing the highest quality of care to all of our patients.

By signing below I state that I understand the Reminder and Missed Appointment policy:

______________________________ ______________________

Signed Name Date

____

Printed Name