

# PATIENT REGISTRATION

<b>Patient's Name</b>		<b>Preferred Name</b>		<b>Sex: M F</b>	
Address		City		State	
Zip		Home Phone: _____		<b>Circle One:</b>	
Birth date: _____		Cell Number: _____		Married	
SS Number: _____		Work Phone: _____		Divorced	
Employer: _____		Email address: _____		Single	
Age: _____				Minor	
<b>Are you a full time student?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		<i>If patient is minor we need:</i>		<i>Mother's Birth Date</i>	
				<i>Father's Birth Date</i>	
Person responsible for account			Driver's license number		
Name of spouse (Parent if minor)		E-mail address		Cell Phone	
Spouse's/Parent's employer		Spouse's Soc. Sec. #		Work phone	
<b>EMERGENCY CONTACT</b> (not living with you)			<b>How did you hear about our office?</b>		
Name: _____			_____		
Address: _____			<b>Reason for this visit?</b>		
Phone: _____			_____		
<b>DENTAL INSURANCE INFORMATION</b> (Primary)			<b>SECONDARY INSURANCE INFORMATION</b>		
<b>Insured's name</b>			<b>Insured's name</b>		
DOB		SS#	DOB		SS#
Insured's employer			Insured's employer		
Insurance Company			Insurance Co		
Insurance Company Address			Insurance Co Address		
Phone #			Phone #		
Group #		ID#	Group #		ID #

Is there any other medical or dental information we should know about? \_\_\_\_\_

List **MEDICATIONS** taken within the last two years \_\_\_\_\_

\_\_\_\_\_  
**PATIENT SIGNATURE** (PARENT/GUARDIAN)                      **DATE**

\_\_\_\_\_  
**DR. SIGNATURE**

# DENTAL HISTORY

Name \_\_\_\_\_

**Please check any of the following that apply to you.**

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| -Sensitivity (hot, cold, sweet)<br>Where? UR LR UL LL | <input type="checkbox"/> | <input type="checkbox"/> |
| -Headaches, earaches, neck pain                       | <input type="checkbox"/> | <input type="checkbox"/> |
| -Jaw joint pain                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| -Teeth or fillings breaking                           | <input type="checkbox"/> | <input type="checkbox"/> |
| -Grinding or clenching teeth                          | <input type="checkbox"/> | <input type="checkbox"/> |
| -Bleeding, swollen or irritated gums                  | <input type="checkbox"/> | <input type="checkbox"/> |
| -Loose, tipped or shifting teeth                      | <input type="checkbox"/> | <input type="checkbox"/> |
| -Bad breath   | <input type="checkbox"/> | <input type="checkbox"/> |

**Do you have or have you had any of the following?**

- |                   |                          |                          |
|-------------------|--------------------------|--------------------------|
| -Dentures         | <input type="checkbox"/> | <input type="checkbox"/> |
| -Partial dentures | <input type="checkbox"/> | <input type="checkbox"/> |
| -Braces           | <input type="checkbox"/> | <input type="checkbox"/> |
| -Gum treatments   | <input type="checkbox"/> | <input type="checkbox"/> |

**Please share the following dates:**

- Your last cleaning \_\_\_\_\_ / \_\_\_\_\_
- Your last oral cancer screening \_\_\_\_\_ / \_\_\_\_\_
- Your last complete X-Rays \_\_\_\_\_ / \_\_\_\_\_

Previous Dentist \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Phone Number \_\_\_\_\_

What is the most important to you about your future smile and dental health? \_\_\_\_\_

**If you could whiten your teeth for a cost anyone could afford, would you do it?**

Yes No

**Do you smoke or use chewing tobacco?**

How much? \_\_\_\_\_ For how long? \_\_\_\_\_

**If I could change my smile, I would:**

- |   |                          |                          |
|---|--------------------------|--------------------------|
| -Make them whiter   | <input type="checkbox"/> | <input type="checkbox"/> |
| -Make them straighter   | <input type="checkbox"/> | <input type="checkbox"/> |
| -Close spaces   | <input type="checkbox"/> | <input type="checkbox"/> |
| -Replace black metal fillings with tooth colored restorations | <input type="checkbox"/> | <input type="checkbox"/> |
| -Repair chipped teeth   | <input type="checkbox"/> | <input type="checkbox"/> |
| -Replace missing teeth  | <input type="checkbox"/> | <input type="checkbox"/> |
| -Replace old crowns that don't match                          | <input type="checkbox"/> | <input type="checkbox"/> |
| -Have a smile makeover  | <input type="checkbox"/> | <input type="checkbox"/> |

**On a scale of 1-10,  
10 being the highest rating:**

-How important is your dental health to you?  
1 2 3 4 5 6 7 8 9 10

-Where would you rate your current dental health?  
1 2 3 4 5 6 7 8 9 10

**Why did you leave your previous dentist?**

What is the most important thing to you about your dental visit today?

# MEDICAL HISTORY

**Please check any of the following that apply to you:**

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Allergies (Seasonal)   | <input type="checkbox"/> Emphysema                  | <input type="checkbox"/> Jaw Joint Pain         | <input type="checkbox"/> Seizures          |
| <input type="checkbox"/> Anemia                 | <input type="checkbox"/> Excessive Bleeding         | <input type="checkbox"/> Kidney Disease         | <input type="checkbox"/> Stomach Problems  |
| <input type="checkbox"/> Arthritis              | <input type="checkbox"/> Fainting                   | <input type="checkbox"/> Liver Disease          | <input type="checkbox"/> Stroke            |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Heart Murmur               | <input type="checkbox"/> Low Blood Pressure     | <input type="checkbox"/> Thyroid Disease   |
| <input type="checkbox"/> Artificial Joints      | <input type="checkbox"/> Heart Conditions           | <input type="checkbox"/> Mitral Valve Prolapse  | <input type="checkbox"/> Tuberculosis      |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Heart Lesions (Congenital) | <input type="checkbox"/> Nervousness/Depression | <input type="checkbox"/> Ulcers            |
| <input type="checkbox"/> Blood Disease          | <input type="checkbox"/> Heart Surgery              | <input type="checkbox"/> Pacemaker              | <input type="checkbox"/> Venereal Diseases |
| <input type="checkbox"/> Bruise Easily          | <input type="checkbox"/> Hepatitis A                | <input type="checkbox"/> Phen Fen (1 month +)   | <input type="checkbox"/> Other _____       |
| <input type="checkbox"/> Cancer _____           | <input type="checkbox"/> Hepatitis B                | <input type="checkbox"/> Radiation (head/neck)  |  |
| <input type="checkbox"/> Chemotherapy           | <input type="checkbox"/> Hepatitis C                | <input type="checkbox"/> Respiratory Problems   |  |
| <input type="checkbox"/> Diabetes               | <input type="checkbox"/> High Blood Pressure        | <input type="checkbox"/> Rheumatic Fever        |  |
| <input type="checkbox"/> Dizziness              | <input type="checkbox"/> Jaundice                   | <input type="checkbox"/> Rheumatism             |  |
| <input type="checkbox"/> Drug Addiction         |   | <input type="checkbox"/> Scarlet Fever          |  |

**WOMEN ONLY**

- Birth Control Pills
- Breast-feeding
- Pregnant

Month: 1-3 3-6 6-9

**Do you have any of the following drug allergies?**

- |   |  |                                     |
|---|--|-------------------------------------|
| <input type="checkbox"/> Codiene          | <input type="checkbox"/> Sulfa Drug    | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Darvon           | <input type="checkbox"/> Valium        | <input type="checkbox"/> Aspirin    |
| <input type="checkbox"/> Erythromycin     | <input type="checkbox"/> Nitrous Oxide |                                     |
| <input type="checkbox"/> Latex            | <input type="checkbox"/> Percodan      |                                     |
| <input type="checkbox"/> Local Anesthetic | <input type="checkbox"/> Other _____   |                                     |

**Are you under a physician's care?**  Yes  No

**What for?** \_\_\_\_\_

**Family Physician** \_\_\_\_\_  
**Phone Number** \_\_\_\_\_

## MEDICATION POLICY

Our patients are very important to us. We always try to provide you with the best treatment possible, in a pleasant and caring environment. We are sensitive to the discomfort you may be feeling, and for that reason, Dr. Slater may give you medication to help with your discomfort.

- Medication should be taken as instructed by Dr. Slater or his assistant.
- Contact your pharmacy for all medication refills.
- If Dr. Slater has prescribed medication for treatment, he cannot refill this prescription until after the treatment has been started.
- Medication refills will need to be requested before 4:00 pm.
- Medications will not be filled on the weekend.
- It is our policy not to prescribe for undiagnosed pain.
- If medication is needed beyond the normal post-operative period, or if discomfort persists after the completion of treatment, you will be referred to a specialist to help with your discomfort.

I have read and understood the policy, or it has been explained to me.

Patient's Name \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness Signature \_\_\_\_\_ Date \_\_\_\_\_

# PHOTO CONSENT FORM

I, \_\_\_\_\_, do hereby give my consent to David Slater, DDS, for the use of my dental photos, videos, and/or portrait as he sees fit for the advancement of cosmetic dentistry, educational viewing by other dental professionals, and in the promotion of cosmetic dentistry with or without my name, or with a fictitious name. I release and forever discharge him from any claims, demands or liabilities on account of such use.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor Signature \_\_\_\_\_ Date \_\_\_\_\_

I am the parent or guardian of the minor named above and have the legal authority to execute the above releases. I approve the foregoing and waive any rights in the premises.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness Signature \_\_\_\_\_ Date \_\_\_\_\_

# NOTICE OF RECEIPT OF PRIVACY PRACTICES

I, \_\_\_\_\_, have been offered a copy of Dr. Slater's privacy Practices Act.

\_\_\_\_\_ I have received a copy, read and understand the Privacy Act.

\_\_\_\_\_ I have read and understand the Privacy Act, but decline a copy.

\_\_\_\_\_ I decline to read or accept a copy of the Privacy Act.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

# OUR FINANCIAL POLICY

We are committed to providing you with the best possible care and we will be happy to discuss our professional fees with you at any time. Your clear understanding of our financial policy is very important to our relationship. We have found that the only problem a patient might have is usually due to lack of communication concerning the finances.

- Cash, Checks, Visa, MasterCard, Discover and American Express.
- Care Credit Medical/Dental Card – Offers up to 12 months zero interest.

**We do not accept insurance on your first visit unless the insurance information has been received and verified prior to your visit.** We will provide you with a receipt or a claim form to enable you to file and insurance will reimburse you directly. On subsequent visits, we ask that you pay your estimated portion. We will file the claim for you. Responsible party is expected to pay any portion of the claim not covered by your insurance company.

Insurance is a contract between you, your employer and the insurance company. We are, in no way, involved in this contract. We file insurance claims as a courtesy to our patients. Although we do our best to estimate your benefits, the patient is ultimately responsible for knowing the specifics of their dental coverage and effective dates or waiting periods.

Patient is responsible for handling any disputes with the insurance company regarding deductibles, covered charges, and secondary insurance, “usual and customary” amounts. *(We have found that when the patient takes responsibility for insisting that their insurance company meet their responsibility, there is a much higher chance of receiving the benefit.)*

As part of the financial arrangement process, we will estimate what your insurance company will pay. In the event that your insurance company denies payment of a service or covers less than estimated, you are responsible for that fee. Any unpaid balance after insurance pays is due immediately.

I(we) understand that I am responsible for payment for dental services provided in this office for myself and/or my dependents. I further understand that all payments are due at the time services are scheduled unless financial arrangements have been made prior. I(we) further understand that a 1½ % finance charge (18% annually) will be added to any balance over 90 days. In the event of default I(we) understand said debt may be sent to collections and/or reported to the credit bureaus. I(we) promise to pay legal fees on the indebtedness, together with such collection cost and reasonable attorney fees that applies to the collection of this note.

Thank you for choosing our office to take care of your dental needs. Our patients are very important to us and we want to always treat you with the same respect and consideration that we would expect to receive from you.

Patient's name \_\_\_\_\_ Date \_\_\_\_\_

Responsible Party Signature \_\_\_\_\_ Relation to patient \_\_\_\_\_