Patient Registration

Patient's Name ________________________________ Preferred Name __________ Age ____ Date of Birth ___________

Address ____ City, State, Zip ________________________________

Home Phone _______________________________________ Cell ____

Work Phone _______________________________ E-mail ____

Best Contact: ▢ EMail ▢ Cell ▢ Text ▢ Home | Best time to reach you: ______________________________________

SS# ___________________________________ Marital Status: ▢ Single ▢ Married ▢ Widowed ▢ Divorced

Employer ___________________________________ Employer Address _______________________________________

Spouse's Name ____ Spouse's Phone ______________________________

Emergency Contact _____________________________ Relation __________________ Phone _______________________

Do you have dental insurance? ▢ Yes ▢ No If yes, insurance carrier's name ______________________________________

Group # __________________ Phone ___________________ Subscriber's Name ________________________________

Relation to Patient ______________________ Subscriber ID # ________________ Subscriber Date of Birth ___________

Employer/Co. Name _______________________________ Phone ____

Employer/Co. Address, City, State, Zip ____

Insurance Carrier Address, City, State, Zip ____

How did you hear about us? ____

Would you like to receive appointment reminders via text message? ▢ Yes ▢ No

OFFICE POLICY REGARDING INSURANCE: Your dental insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. The responsibility of payment ultimately lies with the patient. As a courtesy, we will file your claim on your behalf. By signing this form you understand that you are required to pay your estimated patient portion and any deductible due to Loveland Dental Group at the time of service. Any portion of treatment that insurance does not cover is the patient's responsibility. A statement will be sent to the patient for any balance which is not paid by the insurance company. You are authorizing the release of any dental information that is needed to file your insurance and you consent to treatment for yourself/family under 18 years old. You have read this statement and understand that you are responsible for payment in full after 45 days of your treatment, regardless of any delay in payment(s) by your insurance company. You understand that a 1.5% per month late charge may be added to your account for any overdue balance that is your responsibility.

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Patient/Guardian Signature Date

Medical History

In order for us to provide you with the safest and best possible care, please complete these medical and dental history forms. All information is kept strictly confidential.

Are you currently taking any prescription drugs? Please list along with dosage and frequency.

___

___

Are you taking any over the counter medications or herbal supplements? If yes, please list.

___

Are you allergic to (i.e. itching, rash, swelling) or made sick by any medication? If yes, please list.

___

Any surgeries or hospitalizations? ___

Have you ever had any excessive bleeding requiring special treatment? ___

Have you ever taken drugs by mouth or injection to strengthen bone for conditions such as Osteoporosis, multiple myeloma, Paget's disease, breast or prostate cancer?___

Have you ever been told to take antibiotics prior to dental treatment? ___

Use of alcohol: ☐Yes ☐ No | ☐Daily ☐Weekly ☐Monthly | Use of recreational drugs: ☐Yes ☐No

Do you use tobacco? ☐Yes ☐No What type and how much per day? ___

Are you pregnant now? ☐Yes ☐No ☐N/A | Are you practicing birth control? ☐Yes ☐No

Check any of the following which you have at the present or have had in the past:

- ☐ LOW BLOOD PRESSURE
- ☐ HIGH BLOOD PRESSURE
- ☐ HEART DISEASE/ATTACK
- ☐ ANGINA PECTORIS
- ☐ ARTIFICIAL HEART VALVE
- ☐ HEART FAILURE
- ☐ HEART PACEMAKER
- ☐ THYROID/GLAND PROBLEMS
- ☐ KIDNEY PROBLEMS
- ☐ SEXUALLY TRANSMITTED DISEASES
- ☐ ACID REFLUX
- ☐ ULCERS
- ☐ LIVER FAILURE
- ☐ HEPATITIS/JAUNDICE
- ☐ DIABETES TYPE I OR II
- ☐ JOINT REPLACEMENT
- ☐ SEIZURES/EPILEPSY
- ☐ ALLERGIES/SINUS TROUBLE
- ☐ ASTHMA/BRONCHITIS
- ☐ EMPHYSEMA/COPD
- ☐ CHEMOTHERAPY
- ☐ RADIATION TREATMENT
- ☐ BRUISE/BLEED EASILY
- ☐ ANEMIA
- ☐ SLEEP APNEA
- ☐ HIV/AIDS
- ☐ ARTHRITIS
- ☐ OSTEOPOROSIS
- ☐ LEUKEMIA
- ☐ STROKE

Have you ever had any serious illness not listed above?___

LOVELAND
DENTAL GROUP

PLEASE READ THE FOLLOWING CAREFULLY: To the best of my knowledge all of the preceding answers are true and correct. If I ever have a change in my health I will inform the office at my next appointment. I do hereby authorize and request for myself, or the above named patient, dental services and/or whatever procedures the doctor may deem necessary. I also authorize the administration of local anesthetic or pre-medications which may be deemed advisable.

Patient/Guardian Signature___

Dental History

Answers to these questions help us provide safe and effective dental care personalized to your individual needs.

ARE ANY OF YOUR TEETH SENSITIVE TO:	**YES**	**NO**
Hot or cold?	☐	☐
Sweets?	☐	☐
Biting or chewing?	☐	☐
Have you noticed any mouth odors or bad taste?	☐	☐
Do you frequently get cold sores?	☐	☐
Do you frequently get oral ulcers?	☐	☐
Do your gums bleed or hurt?	☐	☐
Have you noticed any loose teeth?	☐	☐
Have your teeth shifted over the years?	☐	☐
Does food tend to become caught in between your teeth?	☐	☐
DO YOU:		
Clench or grind your teeth while awake or asleep? Have tired jaws, especially in the morning?	☐	☐
Have a hard time opening wide?	☐	☐
Mouth breathe while awake or asleep?	☐	☐
Hold foreign objects with your teeth (i.e. pencils, nails)? Chew ice often?	☐	☐
HAVE YOU EXPERIENCED ANY OF THE FOLLOWING:		
Clicking or popping of the jaw?	☐	☐
Pain in the jaw joint area near the ear?	☐	☐
Difficulty in opening or closing your mouth?	☐	☐
Headaches, neck aches, or shoulder aches frequently?	☐	☐
Sore muscles in the neck or shoulders?	☐	☐

I WOULD LIKE TO LEARN MORE ABOUT:

☐ Orthodontics ☐ Cosmetic Dentistry ☐ Implants

☐ Whitening ☐ Bridges ☐ Dentures ☐ Other____________________

When was your last dental visit? ____________________

What was completed during your last dental visit? ____________________

Last dental x-rays? ____________________ How often do you have dental examinations? ____________________

What other dental aids do you use? (electric brushes, toothpicks, etc.) ____________________

Do you have any dental problems that you are aware of now?

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Do you feel nervous about dental treatment? If yes, what is your biggest concern?

____

Health Insurance Portability and Accountability Act (HIPAA)

I understand that I have certain rights regarding my protected health information, or, Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (i.e. insurance company)
- The day to day healthcare operations of the dental office (including appointments, billing and treatment)

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that I have been given the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care options. (For example, if you are over 18 years old, you may wish to add a spouse, parent, child, or guardian.)

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Person to whom we
may release information to:_________________________ Relationship to Patient: _________________________

Person to whom we
may release information to:_________________________ Relationship to Patient: _________________________

Patient/Guardian Signature_______________________________________ Date___________________________

Financial Arrangements

Payment is due at the time of service. Patients with insurance will be expected to pay their "estimated patient portion" which is calculated based upon the information we receive from the particular insurance company. This estimated amount will be due on or before the day of service. Any balance due after the insurance has paid will be billed to the patient and due within thirty (30) days of the statement date.

Payment Options:

- Cash, Cashier's Check, Personal Check
- MasterCard, Visa, Discover, American Express
- Patient financing - We work with several financial organizations that will allow you to get the treatment you need now and spread the payments over as much as 24 months, including "no interest" programs.

Our mission is to help you achieve the best possible dental health. Our job is to evaluate the state of your oral health and then discuss with you our findings and potential treatment options. We will always give you all of the options that pertain to your condition. You job is to determine what treatment option is best for you and the pace at which you wish to proceed with your treatment. We will gladly respect your decisions.

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Patient/Guardian Signature

Cancelation Policy

Routine appointments require a 48-hour advance notice to reschedule.

This will allow us time to offer your reserved appointment to someone who is waiting for an appointment and may also be in pain. Missed appointments and appointments canceled with less than 48 hours notice may be subject to a fee.

We know there are things that happen in life like flat tires, illness, and unforeseen circumstances that do come up. If you just let us know, we can help another patient with a dental emergency instead.

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Patient/Guardian Signature