Patient Registration

First Name:_____ Last Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Birth date:_____ Soc Sec:_____ Male_____ Female_____

Single_____Married_____Separated_____Divorced_____Widowed_____

Who may we thank for referring you? *_____*

Please Provide at least 2 contact numbers:

*Home phone**_____ Work phone*_____*

*Cell*_____* ***Email*_____***

Dental Insurance Information:

Primary Dental Insurance Company:_____

Policy Holder:_____ Policy Holder's Date of Birth:_____

Policy Holder's Address_____ Phone number:_____

ID or Soc Sec #_____ Employer:_____

Secondary Dental Insurance Company: _____

Secondary Policy Holder:_____ Date of Birth:_____

Policy Holder's Address:_____ Phone number:_____

ID or Soc Sec #_____ Employer:_____

I hereby acknowledge that I have read this Dental Practice's HIPAA Notice of Privacy Practices.

I have read and understand the foregoing information and that my signature below signifies my agreement to comply with the above terms. In the event of a breach or threatened breach of the Confidentiality Agreement, I acknowledge that appropriate disciplinary actions may be a result.

Patient/Guardian Signature:_____

Print/name_____ Date _____

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____

Are you on a special diet? ◯ Yes ◯ No

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
- ☐ Pregnant/Trying to get pregnant?
- ☐ Nursing?
- ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Sulfa Drugs

☐ Other If yes, please explain: _____

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

- ☐ AIDS/HIV Positive
- ☐ Alzheimer's Disease
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Breathing Problem
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Cold Sores/Fever Blisters
- ☐ Congenital Heart Disorder
- ☐ Convulsions
- ☐ Cortisone Medicine
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Easily Winded
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Fainting Spells/Dizziness
- ☐ Frequent Cough
- ☐ Frequent Diarrhea
- ☐ Frequent Headaches
- ☐ Genital Herpes
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack/Failure
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Heart Trouble/Disease
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hives or Rash
- ☐ Hypoglycemia
- ☐ Irregular Heartbeat
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Pain in Jaw Joints
- ☐ Parathyroid Disease
- ☐ Psychiatric Care
- ☐ Radiation Treatments
- ☐ Recent Weight Loss
- ☐ Renal Dialysis
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Spina Bifida
- ☐ Stomach/Intestinal Disease
- ☐ Stroke
- ☐ Swelling of Limbs
- ☐ Thyroid Disease
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors or Growths
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Yellow Jaundice

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

APPOINTMENT POLICY

Platinum Dental Group strives to provide our patients with the best dental care at reasonable rates. In an effort to do so, we will continuously manage all of our available resources by instituting these Appointment and Financial Polices with our patients.
Please review our Appointment and Financial Policies carefully and fill out the appropriate information. A copy of this information is available upon request from the Front Office Coordinator.

APPOINTMENT POLICY
DEFINITION OF "NO-SHOW": A "No-show" is a patient who:
- o **Does not show up** for their scheduled appointment.
- o **Cancels** or **reschedules** their appointment with **less than 24 hours notice.**

A. OUR RESPONSIBILITY TO OUR PATIENTS:
- o For your convenience, we will call with an appointment reminder ***at least* 2 days prior to your scheduled appointment.**

B. OUR PATIENTS' RESPONSIBILITY:
- o We require **a minimum of 24 hours notice** to reschedule an appointment.
- o If you cancel your appointment with less than 24 hour notice or do not show up for your appointment, a fee of $100 dollars will be added to your account

I certify by my signature that I have read the above Appointment Policy and will comply.

_____ ___/___/_____
Signature **Date**

FINANCIAL POLICY

o Our patients should provide current insurance information at each office visit, or upon request

o Unpaid balances will be paid **within 45 days** of office visit.

o All balances **older than 90 days** will be **turned over to a collection agency** for payment and/or legal action.

o For your convenience we accept **Visa, MasterCard, Discover.**

o We have teamed up with **Care Credit Financial** plan to offer an affordable way to achieve their optimal treatment goals. For more information, ask to speak with our Financial Coordinator

o There will be a **$25.00 return fee charge for all returned checks**. After that, we will no longer be able to accept checks as an acceptable form of payment.

o We offer a **5% discount for payment in full on treatment plans totaling $500.00**. This discount does not apply to insurance co-payments or office visit fees.

o All treatment payment plans involving your insurance company is **only an estimate and not a guarantee of coverage.**

o Any charges not covered under an insurance plan will be patient's responsibility. We will assist where possible; however **we will not pursue collection from your insurance company, or any third party, on your behalf.**

o **Emergency patients** who are not of record **shall pay for services when they are rendered**. We will assist in providing the necessary information you may need to file a claim with your insurance company.

o We do offer reasonable payment plans. For these options, **payment is due as defined in the payment plan** and payment in full will coincide with completion of treatment.
I certify by my signature that I have read the above Financial Agreement and will comply.

_____ ___/___/_____
Signature **Date**