Registration and Dental History

Patient's Name (First): (Last): (Middle Initial):

Preferred Name: Date of Birth: Age: Sex: **MALE FEMALE**

Address: City, State, Zip:

Cell Phone#: Work #: Other #:

E-Mail: Best Contact: **EMAIL TEXT CELL HOME**

Social Security#: Driver's License #:

Marital Status: **SINGLE MARRIED WIDOWED SEPARATED DIVORCED**

Spouse's Name or (If a minor) Parent's Name:

Spouse's Work Phone: Cell #:

RESPONSIBLE PARTY INFORMATION

Responsible Party Name (if different from patient): Relationship:

Responsible Party Address, City, State, Zip:

Home Phone#: Work #: Cell #:

Employer: Employer Address:

INSURANCE & EMPLOYER INFORMATION

Insurance Carrier Name:

Subscriber's Name: Subscriber's Date of Birth:

Relation to Patient: **SELF SPOUSE CHILD OTHER** Subscriber's Phone #:

Subscriber's SS#: Insurance ID #: Group #:

Insurance Carrier Address, City, State, Zip:

Medicaid #:

Employment Status: **FULL TIME PART TIME UNEMPLOYED** Student Status: **FULL TIME PART TIME**

Employer: Phone #:

Employer Address, City , State, Zip:

DENTAL INFORMATION

Do your gums bleed when you brush? **YES NO Don't Know**

Have you ever had orthodontic (braces) treatment? **YES NO Don't Know**

Are your teeth sensitive to cold, hot, sweets or pressure? **YES NO Don't Know**

Do you have earaches or neck pains? **YES NO Don't Know**

Have you had any periodontal (gum) treatments? **YES NO Don't Know**

Do you wear removable dental appliances? **YES NO Don't Know**

How do you feel about the appearance of your teeth? _____

If you have a current dental problem, how would you describe it? _____

What was the name of your previous dentist? _____ Office #: _____

Date of your last dental exam: _____ Date of your last dental x-rays: _____

What was done at that time? _____

EMERGENCY CONTACT

Emergency Contact: Phone/Cell #:

(Please list closest relative or friend whose address is different from yours)

Relationship to Patient:

Emergency Contact Address, City, State, Zip:

Preferred Pharmacy: Phone #:

OTHER

How did you hear about us?

Have you or another member of your family been treated here? If so, who?

Would you like to receive appointment reminders via text messages; **YES NO** via email? **YES NO**

MEDICAL HISTORY

To help us to provide you with the safest and best care, please complete this Medical History form. All information is kept strictly confidential

Are you taking or have you recently taken any prescription or over the counter medicine(s) Please list: **YES NO**

Are you currently under a physician's care? If so, name and phone # of physician: **YES NO**

List any surgeries and/or hospitalization within the last 5 years: **YES NO**

Are you now having or have you ever had radiation to the head or neck? **YES NO**

Have you ever taken bone density medications such as Fosamax, Boniva, Actonel or any other medications containing bisphosphonates for cancer or osteoporosis? Please list: **YES NO**

Have you ever or are you currently taking prescription blood thinners or Aspirin? **YES NO**

Do you use tobacco? What type and how much per day? **YES NO**

Do you drink alcohol? If so, how much and how often? **YES NO**

Do you use "street drugs"? If so, Please list? **YES NO**

Are you pregnant? **YES NO** | Taking birth control? **YES NO** | Plan to become pregnant? **YES NO** | Nursing? **YES NO**

Are you allergic to any of the following?

OAspirin OPenicillin OPeanuts OCodeine OAcrylic OLocal Anesthetics
OMetal OLatex OBananas OSulfa Drugs OOther_____

Please indicate if you have or previously had any of the following diseases or problems:

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

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 office of any changes in medical status.

Print Patient Name

Signature of Patient or Guardian Date

Draper Family & Cosmetic Dentistry
Patient Appointment Agreement

Welcome and thank you for choosing Draper Family & Cosmetic Dentistry for your oral healthcare needs. We are committed to providing you with the best possible service and appreciate the trust you have placed in our team of professionals.

It is important for you to understand and agree to the following information to avoid any misunderstanding about our appointment policies.

After two failed/broken appointments, you may no longer be allowed to reserve appointments. Each failed/broken appointment may result in a $50 charge. A failed or broken appointment is defined as:

- Not showing up for your reserved appointment time.
- Arriving more than 10 minutes late for your reserved appointment time without prior notice.
- Calling to cancel your reserved appointment time with less than 24 hours notice.

Appointment Reminders

Appointment Confirmation: It is critical for us to be able to confirm your appointment before the scheduled date since many appointments are reserved weeks in advance. We will try to contact you two working days in advance of your scheduled appointment using phone call, text, and/or email communication documented in our system. ***Appointments that are not confirmed by noon the working day before the reserved time may be canceled and another patient may be offered that appointment opportunity.***

Check-in: Please arrive 15 or more minutes before your reserved appointment time and check-in with the receptionist at your arrival time. You will be asked to pay your portion for services scheduled. Be prepared to provide a driver's license or photo ID or have your photo taken. Bring a copy of your medication list and any pertinent medical doctor releases. (For example, heart, implant, replacement or pregnancy.)

Check-out: Please check-out at the reception desk to schedule your next appointment.

Insurance: If you have dental insurance, please give us any written plan information you have been given by your employer at least 72 hours in advance so that we may help you maximize your insurance benefits and avoid out of pocket expense to yourself.

Financial: All accounts must be current. Patients who have account balances 45 or more days past due may not be allowed to schedule appointments.

Rescheduling/Canceling an Appointment: If you need to reschedule or cancel a reserved appointment, please contact our office by phone 48 hours in advance. Cancellations or changes are not accepted by email or text

I have read and understand the **Patient Appointment Agreement** and agree with its terms.

_____

Print Patient Name

_____ _____

Patient or Guardian Signature Date

Draper Family & Cosmetic Dentistry
Financial Policy Agreement

Welcome to Draper Family & Cosmetic Dentistry. We appreciate your selecting us as your dental provider. We are committed to providing you and your family with the best possible service and appreciate the trust you have placed in our team of professionals. Before we perform any service, an explanation of your recommended treatment, treatment options, and a reasonable estimate of treatment fees will be presented to you for your approval.

We ask that you carefully review and sign our **Financial Policy Agreement** before beginning treatment, and we encourage you to talk with us regarding any problems that may affect your ability to afford care.

Payment for Services is expected at the time service is provided unless other financial arrangements have previously been made with our Office Manager. This includes any insurance or other third party deductible or co-payment. We accept cash, personal check, Care Credit, money order, and most major credit cards.

Dental Insurance claims will be filed as a courtesy for most dental insurance plans provided that you have assigned benefits to Draper Family & Cosmetic Dentistry. Please contact your insurance carrier or consult your certificate of coverage for details pertaining to deductibles, co-payments, maximums, covered and non-covered services, and plan restrictions.

Please plan to bring a copy of your insurance card or verification of coverage to each appointment. Failure to provide our office with all the information necessary to file your insurance claim will require full payment at the time of service.

Your insurance policy is a contract between you or your employer and the insurance company. Draper Family & Cosmetic Dentistry is not a party to that contract. Our relationship is with you, the patient, and not the insurance company. Therefore, you (or your account guarantor) are ultimately financially responsible for all services provided, including services that are not covered by your policy.

Miscellaneous Financial Information:

- Returned checks will result in an NSF fee of $25 charged to your account. Services to you and your family cannot continue until the returned check balance and NSF fee have been paid in full.
- Balances that are not current and are greater than 45 days past due may result in a loss of appointment privileges and are subject to transfer to a third party collections management company. Under these circumstances, emergency services will be available only on a fee for service basis.
- Balances greater than 30 days past due will incur a 1.5% interest charge each month the balance is unpaid.
- Each failed/broken appointment may result in a $50 charge.

My signature acknowledges that I have read, understand, and accept these **Financial Policy Agreement** terms.

_____

Print Patient Name

_____ _____

Patient or Guardian Signature Date

Draper Family & Cosmetic Dentistry
Parental Treatment Consent
For Child(ren) Under 18 Years of Age

I,_____, parent/legal guardian of the following:
Child(ren):

_____

give the below named person(s) permission to accompany my child to dental appointments, allowing them to make financial and treatment decisions on my behalf. I understand that medical history and consent must be updated and signed yearly by a parent or guardian. I understand that VERBAL CONSENT CANNOT BE ACCEPTED.

I understand that the person bringing the child must be 18 years or older, must be listed below and will be asked to show a valid picture ID.

I understand that a child under the age of 18 years old must be accompanied by an adult whose name is listed below.

I understand that in order to remove someone from this list a parent or legal guardian must come in person with valid ID and sign a new consent.

Person(s) and Relationship to Patient:

_____
Print Name Relationship

_____
Print Name Relationship

_____
Print Name Relationship

_____
Parent/Legal Guardian Signature: Date:

Draper Family & Cosmetic Dentistry
Authorization for Release of Information – Friends & Family

Patient Name and Address:_____

Entity to Receive Information:
( ) Spouse (provide name and phone number) ( ) Parent (provide name and phone number)

_____ _____

( ) Other (provide name and phone number)

_____

( ) Email Communication (provide email address)*

_____

*In order for email communication to occur, please accept the disclosure below:

( ) For email communication, I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to move forward to allow email communication to occur.

Description of information to be released. Check each that can be given to person/entity in this section:

( ) Family Billing / Financial Information
( ) Voice Mail / Appointment Reminders
( ) Dental Treatment Plans / X-Rays
( ) Breach Notification

Patients Rights:

- I understand that I have the right to revoke this authorization at any time
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

The information is released at the patient's request and this authorization will remain in effect until revoked by the patient.

_____

Signature of Patient or Personal Representative: Date:
Description of Personal Representative's Authority (attach necessary documentation)

Draper Family & Cosmetic Dentistry

Acknowledgment of Receipt
Of Notice of Privacy Practices

Patient Name & Address: _____

_____

_____

I have received a copy of the Notice of Privacy Practices for the above named practice.

_____ _____

Signature Date

For Office Use Only

We were unable to obtain a written acknowledgment of receipt of the Notice of Privacy Practices because:

- ❑ An emergency existed & a signature was not possible at the time.
- ❑ The individual refused to sign.
- ❑ A copy was mailed with a request for a signature by return mail.
- ❑ Unable to communicate with the patient for the following reason:

  _____
- ❑ Other: _____

  _____

Prepared By _____

Signature _____

Date _____