

DENTAL REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____ First Name _____ Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex M F Age _____

Birthdate _____

Married Widowed Single Minor

Separated Divorced Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 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 _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to _____

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges 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 payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

 Signature of Patient, Parent, Guardian or Personal Representative

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

 Date

 Relationship to Patient

3 PHONE NUMBERS

Home (_____) _____ Work (_____) _____ Ext _____ Cell Phone (_____) _____

Spouse's Work (_____) _____ Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

4 DENTAL HISTORY

Reason for today's visit _____	Burning sensation on tongue <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth breathing <input type="checkbox"/> Yes <input type="checkbox"/> No
_____	Chew on one side of mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth pain, brushing <input type="checkbox"/> Yes <input type="checkbox"/> No
Former Dentist _____	Cigarette, pipe, or cigar smoking <input type="checkbox"/> Yes <input type="checkbox"/> No	Orthodontic treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
City/State _____	Clicking or popping jaw <input type="checkbox"/> Yes <input type="checkbox"/> No	Pain around ear <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental visit _____	Dry mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Periodontal treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental X-rays _____	Fingernail biting <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to cold <input type="checkbox"/> Yes <input type="checkbox"/> No
Place a mark on "yes" or "no" to indicate if you have had any of the following:	Food collection between the teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to heat <input type="checkbox"/> Yes <input type="checkbox"/> No
Bad breath <input type="checkbox"/> Yes <input type="checkbox"/> No	Foreign objects <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to sweets <input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding gums <input type="checkbox"/> Yes <input type="checkbox"/> No	Grinding teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity when biting <input type="checkbox"/> Yes <input type="checkbox"/> No
Blisters on lips or mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Gums swollen or tender <input type="checkbox"/> Yes <input type="checkbox"/> No	Sores or growths in your mouth <input type="checkbox"/> Yes <input type="checkbox"/> No
	Jaw pain or tiredness <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you floss? _____
	Lip or cheek biting <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you brush? _____
	Loose teeth or broken fillings <input type="checkbox"/> Yes <input type="checkbox"/> No	

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HEALTH HISTORY

Physician's Name _____ Date of last visit _____

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. Yes No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). Yes No

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

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting or dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis, Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis Type _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Special Diet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding abnormally, with extractions or surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Feet or Ankles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Neck Glands	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Lesions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumor or growth on head or neck	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cortisone Treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough, persistent or bloody	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervous Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weight Loss, unexplained	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you wear contact lenses?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Women:

Are you pregnant? Yes No

Due date _____

Are you nursing? Yes No

Taking birth control pills? Yes No

MEDICATIONS

ALLERGIES

List any medications you are currently taking and the correlating diagnosis:

Pharmacy Name _____

Phone (____) _____

Aspirin

Barbiturates (Sleeping pills)

Codeine

Iodine

Latex

Local Anesthetic

Penicillin

Sulfa

Other _____

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UPDATES (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? Yes No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Has there been any change in your health since your last dental appointment? Yes No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Oral Screening Consent Form

Page 1 of 1

PLEASE INITIAL EACH PARAGRAPH AFTER READING. IF YOU HAVE ANY QUESTIONS, PLEASE ASK YOUR DOCTOR or Hygienist BEFORE INITIALING.

_____ 1. We are concerned about oral cancer and screen for it on every patient. In addition to the traditional method of screening that we have used in the past, we are now adding a new tool for the screening of oral mucosal tissues.

_____ 2. To provide our patients with the optimal level of care, we have added the Velscope®, fluorescence visualization technology. The Velscope® uses a safe blue light that shines onto and through the oral tissue and has different fluorescence responses to help differentiate between normal and abnormal tissue.

_____ 3. The Velscope® system is the only adjunctive device cleared by the FDA to help discover oral mucosal lesions that might not be apparent or visible to the naked eye. The screening is painless, non-invasive, with no rinses or stains required and will be completed during your visit today.

_____ 4. This enhanced screening is recognized by the American Dental Association, however, this screening may not be covered by your insurance. The fee for this enhanced screening is \$35.00. We recommend this screening once per year.

_____ 5. If you decline this enhanced Velscope® screening, we will still perform the traditional oral cancer surface screening, as we have in the past.

I understand that dentistry is not an exact science and that no specific results can be assured or guaranteed. I acknowledge that no such guarantees have been made regarding the dental screening I have authorized.

CONSENT: I have had the opportunity to have all my questions answered by my doctor and I certify that I understand English. My signature below signifies that I understand the screening that is proposed for me.

YES, I authorize the clinician to perform the Velscope® screening along with the standard oral cancer screening. I accept financial responsibility for this enhanced screening.

NO, I would prefer not to have the Velscope® screening at this time.

Print Name: _____

Patient's (or Legal Guardian's) Signature: _____ Date: _____

Witness' Signature: _____ Date: _____

**Sales Family Dental
Financial Policy**

Patient's Name _____

Dear Patient:

Thank you for choosing Sales Family Dental as your dental care provider. The following is our Financial Policy. Our main concern is that you receive the proper and optimal treatment needed to maintain your dental health.

Payments for services are due at the time services are rendered. We accept cash, checks, and most major credit cards. There will be a \$50 fee on all returned checks. We will be happy to process your insurance claim for you as long as you provide us with adequate information. However you must understand the following:

1. Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. Our relationship is with you, not your insurance company. Initial _____
2. All charges are your responsibility, regardless of whether your insurance company pays. Not all services are covered benefit in all contracts. Some insurance companies arbitrarily select services they will not cover. Initial _____
3. Fees for the services, along with unpaid deductibles and co-payments are due at the time of treatment. If the insurance company does not pay your balance in full within 30 days, we ask that you contact the carrier to help expedite the processing of your claim. Initial _____
4. If the insurance company does not pay in full within 90 days, we require you to pay the balance due with cash, checks, or credit card. In the event that your balance is over 90 days, you will be sent to collections. An additional 20% collection fee of the outstanding balance will be added. Initial _____
5. You will be responsible for notifying us of any changes in address, job status, insurance status, and availability of benefits immediately. A failure to do so may result in a different balance for which you will be responsible. Initial _____

Please note that unless canceled at least 48 hours in advance, you may be charged for missed appointments at the rate of \$50.00. Please call if you have to reschedule or cancel your appointment at least 48hrs in advance.

Initial _____

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems so that we can assist you in the management of your account. Again, thank you for choosing us as your dental provider. We appreciate your trust in us and the opportunity to serve you.

I have read and I understand the above Financial Policy. By signing below, I acknowledge responsibility and agree to the terms above.

Patient's Signature _____ Date: _____
(If patient is a minor, parent or guardian must sign)

Parent's or Guardian's Name _____

Sales Family Dental

1735 Keller Springs Rd. Suite 212

Carrollton, Texas 75006

972-245-4886

ACKNOWLEDGE OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Health Insurance Privacy Protection Act.

Print Name

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Health Insurance Privacy Protection Act, 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):