

PATIENT REGISTRATION

Today's Date _____

Patient's Name	Prefers to be called by	Birthdate	Age
Home Address	City	State	Zip
Please Check One: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Widow			
Home Ph. #	Cell Ph. #	Soc. Sec. #	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Your Employer	Work Ph. #	How Long Employed	
Are you a full time student? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If patient is a minor we need:</i>		Mother's DOB	Father's DOB
Person responsible for account		Driver's License #	Relationship
Name of spouse (parent if minor)		Spouse's Soc. Sec. #	
Spouse's (parent's) Employer		Work Ph. #	Cell Ph. #
EMERGENCY INFORMATION			
<i>Name, address, & telephone of a relative not living with you.</i>			

Reason for this visit _____

How did you hear about our office? _____

DENTAL INSURANCE INFORMATION (Primary Carrier)	If you have double coverage, complete this for the 2nd coverage
Insured's name	Insured's name
Insured's employer	Insured's employer
Insurance Co	Insurance Co
Insurance Co Address	Insurance Co Address
Phone # DOB	Phone # DOB
SS#	SS#
Group # Local #	Group # Local #

FINANCIAL POLICY

Thank you for choosing our office as your dental health care provider. We are committed to providing you with the highest quality lifetime dental care, so that you may fully attain optimum oral health. Payment is due at the time service is provided. Our office accepts cash, personal checks, and credit cards. Outside financing is available upon request and approval.

Please check if you would like more information about financing options.

Please Note: Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance, you will be responsible for any collection and/or legal charges incurred up to 35%.

Do You Have Insurance?

- As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible.
- All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Our office is not a party to that contract.
- Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for the service we provide. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company, by cash, check, or credit card at the time we provide the service to you.
- Insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our financial policy.

Consent:
 I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO MY DENTAL OFFICE. The undersigned hereby authorizes Dr. Nelson to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Nelson to make a thorough diagnosis of the patient's dental needs. I also authorize Dr. Nelson to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge and/or attorney fee will be added to any overdue balance.

Patient Signature (Parent of Child) _____

Date _____

DENTAL HISTORY

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

- Sensitivity (hot, cold, sweet, pressure)
 - Where? UR LR UL LL
- Headaches, earaches, neck pain
- Jaw joint pain
- Teeth or fillings breaking
- Grinding or clenching teeth
- Bleeding, swollen or irritated gums
- Loose, tipped or shifting teeth
- Bad breath
- Do you have or have you had any of the following?
- Dentures
- Partial dentures
- Braces
- Periodontal (gum) treatments
- Please share the following dates:
 - Your last cleaning _____ / _____
 - Your last oral cancer screening _____ / _____
 - Your last complete X-Rays _____ / _____
- Name of Previous Dentist _____
- City _____ State _____
- Phone Number _____

Yes No

- Do you snore?
- Has anyone reported that you choke or gasp for air while sleeping?
- What is your neck size? (inches) _____
- Do you wake refreshed?
- Are you excessively tired during the day?
- Do you smoke or use chewing tobacco?
- How much? _____ For how long? _____
- If I could change my smile, I would:
 - Make them whiter
 - Make them straighter
 - Close spaces
 - Replace black metal fillings with tooth colored restorations
 - Repair chipped teeth
 - Replace missing teeth
 - Replace old crowns that don't match
 - Have a smile makeover

ON A SCALE OF 1 - 10, WITH 10 BEING THE HIGHEST RATING:

- How important is your dental health to you?

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

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----
- Where do you want your dental health to be?

1	2	3	4	5	6	7	8	9	10
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Why did you leave your previous dentist? _____

What is the most important thing to you about your future smile and dental health? _____

MEDICAL HISTORY

Please check any of the following that apply to you:

- | | | | |
|--|--|--|--|
| <ul style="list-style-type: none"> <input type="checkbox"/> AIDS <input type="checkbox"/> Allergies (Seasonal) <input type="checkbox"/> Anemia <input type="checkbox"/> Angina (Chest pain) <input type="checkbox"/> Arthritis <input type="checkbox"/> Artificial Heart Valve <input type="checkbox"/> Artificial Joints <input type="checkbox"/> Asthma <input type="checkbox"/> Blood Disease <input type="checkbox"/> Bruise Easily <input type="checkbox"/> Cancer <input type="checkbox"/> Cervical Cancer <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Cortisone Medication <input type="checkbox"/> Diabetes <input type="checkbox"/> Dizziness <input type="checkbox"/> Drug Addiction | <ul style="list-style-type: none"> <input type="checkbox"/> Emphysema <input type="checkbox"/> Excessive Bleeding <input type="checkbox"/> Fainting <input type="checkbox"/> Glaucoma <input type="checkbox"/> Heart Conditions <input type="checkbox"/> Heart Lesions (Congenital) <input type="checkbox"/> Heart Murmur <input type="checkbox"/> Heart Surgery <input type="checkbox"/> Hepatitis A <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis C <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> HIV Positive <input type="checkbox"/> HPV (Human Papilloma Virus) <input type="checkbox"/> Jaundice <input type="checkbox"/> Jaw Joint Pain <input type="checkbox"/> Kidney Disease | <ul style="list-style-type: none"> <input type="checkbox"/> Liver Disease <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Mitral Valve Prolapse <input type="checkbox"/> Nervousness/Depression <input type="checkbox"/> Pacemaker <input type="checkbox"/> Phen Fen (1 month +) <input type="checkbox"/> Pregnant Currently <input type="checkbox"/> Osteoporosis <ul style="list-style-type: none"> <input type="checkbox"/> Fosamax <input type="checkbox"/> Actonel <input type="checkbox"/> Reclast <input type="checkbox"/> Boniva <input type="checkbox"/> Radiation (head/neck) <input type="checkbox"/> Respiratory Problems <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Rheumatism <input type="checkbox"/> Scarlet Fever | <ul style="list-style-type: none"> <input type="checkbox"/> Seizures <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Stomach Problems <input type="checkbox"/> Stroke <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Ulcers <input type="checkbox"/> Venereal Disease <input type="checkbox"/> Other _____ |
|--|--|--|--|

Do you have any of the following drug allergies?

- | | |
|---|--|
| <ul style="list-style-type: none"> <input type="checkbox"/> Aspirin <input type="checkbox"/> Codeine <input type="checkbox"/> Davron <input type="checkbox"/> Erythromycin <input type="checkbox"/> Latex <input type="checkbox"/> Local Anesthetic <input type="checkbox"/> Nitrous Oxide | <ul style="list-style-type: none"> <input type="checkbox"/> Penicillin <input type="checkbox"/> Percodan <input type="checkbox"/> Sulfa <input type="checkbox"/> Tetracycline <input type="checkbox"/> Valium <input type="checkbox"/> Other _____ |
|---|--|

Are you under a physician's care? What for? _____

Are you taking any medications? What? _____

Family Physician _____ Phone Number _____

Patient Signature (Parent of Child) _____ Date _____

Dentist Signature _____