PATIENT REGISTRATION

Please take a moment to enter your information to help us provide excellent care.

Patient Information

Date:	Patient Name:		
Address:	City:	State:	Zip:
Home #:	Cell #:	Work #:	
Email:		Social Security #:	
Birth date:	Age:	Gender: M / F	
Marital Status: Married	Single	Widowed	Divorced
If minor: School:		Grade:	
Occupation:	Employer:		
Business Address:			
Interests/Hobbies:			
Preferred Appointment Day:	Preferred time: Morning / Afternoon / Anytime		
Whom may we thank for referring you to our practice?			

Spouse or Responsible Party

Name:	Relationship to Patient:	
Address: *(if different from above)*		
City:	State:	Zip:
Home #:	Cell #:	Work #:
Employer:		
Business Address:		

Dental Insurance

PRIMARY Insurance Company Name:	Phone #:
Employee:	Employer:
Date employed:	Date of Birth:
Group No:	Employee Social Security No.:
SECONDARY Insurance Company Name:	Phone #:

Emergency Contact

Name :	Relationship:		
Home #:	Cell #:	Work #:	
Address:	City:	State:	Zip:
Name of closest relative not living with you:			
Home #:	Cell #:	Work #	
Address:	City:	State:	Zip:

Please turn over and sign

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) ____’s dental needs.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

Signature of patient, parent or guardian: ______________________________ Date: _______________

Witness: ____

Dental Smiles
Divya Shetty, D.M.D

DENTAL HISTORY

Name: ___________________________ Date___________

What is the reason for your visit today? ____
____

Date of Last Dental Visit: ___________ Last Dental Cleaning: _____________ Last Full Mouth X-Rays: _____________
Previous Dentist's Name____ City/State _________________________
How often do you have dental examinations? ____
How often do you brush your teeth? ___________ Do you use a manual or electric toothbrush? __________________
How often do you floss? ____________________ Do you use mouthwash? _________________________________
What other dental aids do you use? (Interplak, toothpick, etc.) ____

Do you have any dental problems now? Yes No
If yes, please describe: ____

Are any of your teeth sensitive to:
Hot or Cold? Yes No
Sweets? Yes No
Biting or Chewing? Yes No

Your mouth:
Have you noticed mouth odors or bad tastes? Yes No
Do your gums bleed or hurt? Yes No
Have you noticed loose teeth or change in bite? Yes No
Does food get caught between your teeth? Yes No

Your parents:
Have your parents experienced gum disease? Yes No
Have your parents experienced early tooth loss? Yes No

Do you:
Frequently get cold sores, blisters or Yes No
Any other lesions? Yes No
Clench or Grind your teeth? Yes No
Bite your lips or cheeks regularly? Yes No
Hold foreign objects with your teeth? Yes No
Mouth breath while awake or asleep? Yes No
Have tired jaws, especially in the morning? Yes No

Have you ever had:
Orthodontic treatment? Yes No
Oral surgery? Yes No
Periodontal treatment? Yes No
A serious injury to the mouth or head? Yes No
Your teeth ground down or bite adjusted? Yes No
A bite plate or mouth guard? Yes No

Have you experienced:
Clicking or popping of the jaw? Yes No
Pain? (joint, ear, side of face) Yes No
Difficulty opening/closing mouth? Yes No
Headaches, neckaches or shoulder aches? Yes No
Sore muscles (neck, shoulders)? Yes No

Your smile:
Are you satisfied with your teeth? Yes No
Would you like to keep all your teeth? Yes No

Dental treatment:
Do you feel nervous about treatment? Yes No
Have you ever had an upsetting experience? Yes No

Is there anything else about having dental treatment that you would like us to know? Yes No
If yes, please describe: ____
____
____

Dental Smiles
Divya Shetty, D.M.D.

MEDICAL HISTORY

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 medications 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 list: ____________________________
____
____

Do you take, or have you taken, Phen-Fen or Redux? □ Yes □ No
Are you on a special diet? □ Yes □ No
Do you use tobacco (chew or smoke)? □ Yes □ No
Do you use controlled substances (street drugs)? □ Yes □ No

Since 2001, were you treated or are you presently scheduled to begin treatment with the intervenous bisphosphonates (Aredia or Zometa) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?
□ Yes □No Date treatment began: ______________________________

Are you allergic to any of the following?
□ Aspirin □ Penicillin □Codeine □Acrylic □ Metal □Latex □Local Anesthetics
□ Other □ Sulfa Drugs □Iodine If yes, please explain: ____

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

AIDS/HIV Positive	□ Yes □ No	Cortisone Medicine	□ Yes □ No	Hemophila	□ Yes □ No	Renal Dialysis	□ Yes □ No
Alzheimer's Disease	□ Yes □ No	Diabetes	□ Yes □ No	Hepatitis A	□ Yes □ No	Rheumatic Fever	□ Yes □ No
Anaphylaxis	□ Yes □ No	Drug Addiction	□ Yes □ No	Hepatitis B or C	□ Yes □ No	Rheumatism	□ Yes □ No
Anemia	□ Yes □ No	Easily Winded	□ Yes □ No	Herpes	□ Yes □ No	Scarlet Fever	□ Yes □ No
Angina	□ Yes □ No	Emphysema	□ Yes □ No	High Blood Pressure	□ Yes □ No	Shingles	□ Yes □ No
Arthritis/Gout	□ Yes □ No	Epilepsy or Seizures	□ Yes □ No	Hives or Rash	□ Yes □ No	Sickle Cell Disease	□ Yes □ No
Artificial Heart Valve	□ Yes □ No	Excessive bleeding	□ Yes □ No	Hypoglycemia	□ Yes □ No	Sinus Trouble	□ Yes □ No
Artificial Joint	□ Yes □ No	Excessive Thirst	□ Yes □ No	Irregular Heartbeat	□ Yes □ No	Spina Bifida	□ Yes □ No
Asthma	□ Yes □ No	Fainting Spells/Dizziness	□ Yes □ No	Kidney Problems	□ Yes □ No	Stomach/Intestinal Disease	□ Yes □ No
Blood Disease	□ Yes □ No	Frequent Cough	□ Yes □ No	Leukemia	□ Yes □ No	Stroke	□ Yes □ No
Blood Transfusion	□ Yes □ No	Frequent Diarrhea	□ Yes □ No	Liver Disease	□ Yes □ No	Swelling of Limbs	□ Yes □ No
Breathing Problem	□ Yes □ No	Frequent Headaches	□ Yes □ No	Low Blood Pressure	□ Yes □ No	Thyroid Disease	□ Yes □ No
Bruise Easily	□ Yes □ No	Genital Herpes	□ Yes □ No	Lung Disease	□ Yes □ No	Tonsillitis	□ Yes □ No
Cancer	□ Yes □ No	Glaucoma	□ Yes □ No	Mitral Valve Prolapse	□ Yes □ No	Tuberculosis	□ Yes □ No
Chemotherapy	□ Yes □ No	Hay Fever	□ Yes □ No	Pain in Jaw Joints	□ Yes □ No	Tumors or Growths	□ Yes □ No
Chest Pains	□ Yes □ No	Heart Attack/Failure	□ Yes □ No	Parathyroid Disease	□ Yes □ No	Ulcers	□ Yes □ No
Cold Sores/Fever Blister	□ Yes □ No	Heart Murmur	□ Yes □ No	Psychiatric Care	□ Yes □ No	Venereal Disease	□ Yes □ No
Congenital Heart Disorder	□ Yes □ No	Heart Pace Maker	□ Yes □ No	Radiation Treatments	□ Yes □ No	Yellow Jaundice	□ Yes □ No
Convulsions	□ Yes □ No	Heart Trouble/Disease	□ Yes □ No	Recent Weight loss	□ Yes □ No		

Have you ever had any serious illness not listed above? □ Yes □ No If yes, please explain: ____
Women: Are you:
Pregnant Trying to get pregnant? □ Yes □ No Taking oral contraceptives? □ Yes □ No Nursing? □ Yes □ No

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 (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 ____________________

Doctor signature ____________________________________ Date______________________

Dental Smiles
Divya Shetty, D.M.D.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have read and reviewed the Notice of Privacy Practices. I understand that a copy can be provided if requested.

____
Print Name

____
Signature

For Office Use Only

Our office attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained for the following reason:

_____ Patient refused to sign
_____ Communication barriers prohibited obtaining the acknowledgement
_____ An emergency situation prevented us from obtaining acknowledgement
_____ Other (Describe below)
____
____
____

Dental Smiles

FINANCIAL POLICY

Thank you for choosing Dental Smiles. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check
- Visa, MasterCard, American Express or Discover Card
- Care Credit : Convenient Monthly Payment Plans[1]
    - Allows you to pay over time
    - No annual fees or pre-payment penalties

* We offer a courtesy accounting adjustment for senior citizens and military personnel who pay for their treatment with cash or check prior to completion of care for treatment plans.

Please note:

- Dental Smiles requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.
- For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.[2]
- A fee of $50 is charged for patients who miss or cancel without 48-hour notice.
- Dental Smiles charges $30 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

____

Patient, Parent or Guardian Signature Date

____

Patient Name (Please Print)

[1]Subject to credit approval

[2]However, if we do not receive payment from your insurance carrier within 30 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.