Parkway Dental

# Patient Registration

**TODAY'S DATE**_____

| **Patient's Name** | **Preferred Name** | **Birth Date** | **Sex** M F |
|---|---|---|---|
| | | | |

| **Home Address** | **City** | **State** | **Zip** |
|---|---|---|---|
| | | | |

| **Home Phone #** | **Your Cell Phone #** | **Your Social Security #** |
|---|---|---|
| | | |

| **Marital Status** | **Your Employer** | **Work Phone #** |
|---|---|---|
| | | |

| **Your Driver's License #** | **Your E-mail Address** | **Are you a full time student?** ☐Yes ☐ No Where: |
|---|---|---|
| | | |

| **Name of Spouse (or parent if minor)** | **Spouse (parent's) Birth Date** | **Spouse (parent's) Soc. Sec. #** |
|---|---|---|
| | | |

| **Spouse (or parent's) address** *if different* | **Spouse (parent's) Hone Phone #** | **Spouse (parent's) Cell #** |
|---|---|---|
| | | |

| **Spouse( or parent's) employer** | **Spouse (parent's) Work #** |
|---|---|
| | |

**EMERGENCY INFORMATION**

**Name, Address, & Telephone of A relative** *not* **living with you***:*

**How did you hear about our office?**

**Reason for today's visit?**

| **DENTAL INSURANCE INFORMATION (Primary Carrier)** | | | **If you have a dual insurance coverage, complete this for the second coverage (this office bills primary ins only)** | | |
|---|---|---|---|---|---|
| **Insured's name** | **DOB** | **SS#** | Insured's name | DOB | SS# |
| | | | | | |

| **Insured's employer** | Insured's employer |
|---|---|
| | |

| **Insurance Co** | Insurance Co |
|---|---|
| | |

| **Insurance Co Address** | Insurance Co Address |
|---|---|
| | |

| **Phone #** | Phone # |
|---|---|
| | |

| **Group #** | **Policy #** | Group # | Local # |
|---|---|---|---|
| | | | |

Is there anything other medical or dental history we should know?

| Patient Signature (or parent of child) | Date | Admin. Use Only |
|---|---|---|
| | | |

# DENTAL HISTORY

**Please check any of the following problems that apply to you:**

- ☐ Sensitivity (hot, cold, sweet)
- ☐ Tooth pain or discomfort when chewing
- ☐ Headaches, ear aches, neck pain
- ☐ Mouth ulcers or cold sores
- ☐ Jaw joint pain
- ☐ Broken tooth or fillings
- ☐ Grinding or clenching teeth
- ☐ Bleeding, swollen or irritated gums
- ☐ Loose, tipped or shifted teeth
- ☐ Bad breath or bad taste in your mouth

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

- ☐ Dentures
- ☐ Partial dentures
- ☐ Braces
- ☐ 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: _____

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

_____

**If you could whiten your teeth for a cost anyone could afford, would you do it?**

_____

**Do you smoke or use chewing tobacco? How much? For how long?**

_____

**If you could change your smile, you would:**

- ☐ Make my teeth whiter
- ☐ Make my teeth straighter
- ☐ Close spaces
- ☐ Replace metal fillings with tooth colored fillings
- ☐ 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
Where would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10

Why did you leave your previous dentist?

_____
_____

**What is the most important thing to you about your dental visit today?**

_____
_____

# MEDICAL HISTORY

**Please check any of the following that apply to you:**

- ☐ Allergies (Seasonal)
- ☐ Anemia
- ☐ Artificial Heart Valve
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Diabetes
- ☐ Dizziness/Fainting
- ☐ Drug Addiction
- ☐ Emphysema
- ☐ Excessive Bleeding
- ☐ Glaucoma
- ☐ Heart Conditions
- ☐ Heart Murmur
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Nervousness/Depression
- ☐ Pacemaker
- ☐ Phen Fen (1 month +)
- ☐ Radiation (head/neck)
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ OTHER (please list):

_____
_____
_____
_____
_____
_____

**For WOMEN Only**

- ❑ Birth Control Pills
- ❑ Breast-feeding
- ❑ Pregnant

1-3 mos,3-6 mos,6-9mos,

**Do you have an allergy to any of the following?**

- ☐ Aspirin
- ☐ Codeine
- ☐ Erythromycin
- ☐ Other: _____
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Nitrous Oxide
- ☐ Penicillin

**What medications are you currently taking?**

_____
_____
_____
_____

**Are you under a physician's care? For what?**

_____

**Family Physician** _____ **Phone Number** _____

**Dr. Signature** _____ **Date** _____

**Preferred Pharmacy** _____ **Location** _____

# *Please take a moment to read our office policies and feel free to ask any questions you may have.*

## CONSENT FOR TREATMENT

**I hereby authorize** PARKWAY DENTAL **and designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate to make a thorough diagnosis.**

Upon such diagnosis, I authorize Parkway Dental and staff to perform all recommended treatment mutually agreed upon by me and to employ such professional assistance as required providing proper care.

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.

I authorize the release of a full report of examination findings, diagnosis, treatment program and ongoing progress report to any referring dentist, physician, chiropractor or primary care physician as indicated on my medical history form. I additionally authorize the release of any medical information to insurance companies for legal documentation to process claims. ***I understand that I am responsible for all charges for treatment to me regardless of insurance coverage.***

## Patient HIPAA

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

• Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
• Obtaining payment from third party payers (e.g. my insurance company);
• The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Pratices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

## Appointments

Our office offers email and text appointment reminders along with a *courtesy* reminder call if you have not already confirmed via your email or text, for your upcoming appointments, generally done two business days in advance. If our call is unanswered or you do not receive our reminder message, this does not cancel your appointment or void any fees that may incur. Our office charges a no show fee for missed appointments and/or appointments not cancelled before **24** hours of the scheduled date. The first missed appointment is $25.00, the second missed appointment is $50, and the third missed appointment is $75 and this warrants dismissal from our practice. This charge is not payable by any insurance company and you will be billed directly for this. If you arrive 15 minutes late or more for your appointment, you may be rescheduled and charged for a late cancellation.

## Agreement for Extension of Credit

In accordance with the Federal Truth-In-Lending Act which requires all doctors to give their patients information in connection with extension of credit, please be advised of the following policies which apply in this office. The responsible party agrees to:

1 .Pay the doctor at the time of treatment or service is received or by previous arrangements.

2. That if payments are extended beyond 90 days from the date of first billing to pay 2.4% per month on the unpaid balance (annual rate 29%) with a minimum charge of $1.00 per month.

I/We agree in the event that *DEBTOR* becomes delinquent and payment is not made on amounts owing under the terms of this agreement, and the balance is placed with a licensed collection agency, *DEBTOR* agrees to pay the fees of the collection agency, which amount is theretofore agreed to be 50% of the outstanding balance at the time the account is placed for collections. The 50% collection agency fee will be calculated and added at the time the account is placed into collections.

## Insurance and Financial

If you have dental insurance, as a *courtesy to you*, we will file claims with your insurance company. We will try to answer any questions you may have about your insurance. Group policies are a contract between the employer and the insurance company. Ultimately it is **your** responsibility to know **your** insurance policy and be familiar with your coverage. If you have questions regarding coverage or payment of any claim please contact your insurance company. Dental insurance in most cases is a benefit with limitations and should not be expected to take care of all costs.

Deductibles and co-pays are due at the time of service. If you have a flex plan reimbursement program thru your employer, we will be happy to provide you, upon payment in full of your account, with whatever documents are needed for you to obtain direct reimbursement. We accept cash, checks, and most major credit cards. We also offer Care Credit for patients who wish to make monthly payments past 90days.

***I have read and understand*** Parkway Dental's ***Consent for Treatment, HIPAA, Appointment policies and Insurance & Financial policies. I have had all of my questions regarding these issues answered by a Patient Coordinator and agree to abide by these policies.***

Patient Signature: _____Date: _____

OR

Parent/Guardian

Signature: _____ Date _____