

PATIENT REGISTRATION

ID: _____ Chart ID: _____
 First Name: _____ Last Name: _____ Middle Initial: _____
 Patient Is: Policy Holder Responsible Party Preferred Name: _____

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____
 Address: _____ Address 2: _____
 City, State, Zip: _____ Pager: _____
 Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____
 Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

Responsible Party is also a Policy Holder for Patient Primary Insurance Policy Holder Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____
 City: _____ State / Zip: _____ Pager: _____
 Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____
 Sex: Male Female Marital Status: Married Single Divorced Separated Widowed
 Birth Date: _____ Age: _____ Soc Sec: _____ Drivers Lic: _____
 E-mail: _____ I would like to receive correspondences via e-mail.

Section 2	Section 3
Employment Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired Student Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time Medicaid ID: _____ Pref. Dentist: _____ Employer ID: _____ Pref. Pharmacy: _____ Carrier ID: _____ Pref. Hyg: _____	Emergency Contact Emergency Contact #

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other
 Insured Soc. Sec: _____ Insured Birth Date: _____
 Employer: _____ Ins. Company: _____
 Address: _____ Address: _____
 Address 2: _____ Address 2: _____
 City, State, Zip: _____ City, State, Zip: _____
 Rem. Benefits: _____ Rem. Deduct: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other
 Insured Soc. Sec: _____ Insured Birth Date: _____
 Employer: _____ Ins. Company: _____
 Address: _____ Address: _____
 Address 2: _____ Address 2: _____
 City, State, Zip: _____ City, State, Zip: _____
 Rem. Benefits: _____ Rem. Deduct: _____

Patient Name:

Birth Date:

Date Created:

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 medication 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 _____

Have you ever been hospitalized or had a major operation? Yes No If yes _____

Have you ever had a serious head or neck injury? Yes No If yes _____

Are you taking any medications, pills, or drugs? Yes No If yes _____

Do you take, or have you taken, Phen-Fen or Redux? Yes No If yes _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No If yes _____

Are you on a special diet? Yes No

Do you use tobacco? Yes No

Do you use controlled substances? Yes No If yes _____

Women: Are you...

Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic
 Metal Latex Sulfa Drugs Local Anesthetics

Other? If yes _____

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

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

Have you ever had any serious illness not listed above? Yes No If yes _____

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 dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X _____

Date: _____

CARNES FAMILY DENTAL
REGISTRATION FORM

Date of your Last Dental Visit:

Name of Office:

Date of last dental X-rays:

Date of
Panorex:

Did you complete treatment:

Date of last cleaning:

Today's Visit: Are you having pain?

What is the main reason for your visit today?

Dental concerns:

- | | | | |
|-------------------------------------------|----------------------------------------------------|---------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> Broken/Chipped | <input type="checkbox"/> Lose Teeth | <input type="checkbox"/> For trapping area | <input type="checkbox"/> Missing teeth/Implants |
| <input type="checkbox"/> Decay/Cavities | <input type="checkbox"/> Sensitive to Hot and Cold | <input type="checkbox"/> Bad Taste in mouth | <input type="checkbox"/> Sensitive when biting |
| <input type="checkbox"/> Discolored Teeth | <input type="checkbox"/> Crooked or Crowded Teeth | <input type="checkbox"/> PAIN | <input type="checkbox"/> Grinding/clenching |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Red Gums | <input type="checkbox"/> Sore Gums | <input type="checkbox"/> Periodontal treatment |
| <input type="checkbox"/> Receding Gums | <input type="checkbox"/> Mouth Sores/Blisters | | <input type="checkbox"/> Bad Breath |

Medical History:

How is your General Health?

Good _____

Fair _____

Poor _____

Are you Currently Under Medical Treatment?

Do you require Antibiotic Premedication before your dental appointments? Yes _____ NO _____

If Yes Why: _____

Physicians Name _____ Number _____

Do we have permission to contact them if needed? _Y N

Do you have a Dental Phobia? ___Yes ___No

If yes: Mild

Moderate

Severe

What are you most afraid of? ___Cleanings

___Injections

___Drill

___Pain during procedure

Briefly explain if you had a bad experience:

Is there any other information we should know to better treat your dental needs?:

Patient/Guardian signature

Date

Carnes Family Dental

Payment Policies:

Patients with Dental Insurance:

We accept dental insurance assignments, with the understanding that any uninsured portion not covered by your insurance plan is to be paid by you on the **same day of service**. As a courtesy, our office will file all applicable insurance forms. Please note that although we strive to provide accurate information, such information is not a guarantee of payment or eligibility with your insurance company. Depending on your specific insurance plan, your dental insurance may not fully cover our office dental fees for the services we render. The difference between our office dental fees and your insurance reimbursement is your responsibility.

____ Initial ____ Date

Returned Checks:

Personal checks that are returned due to "insufficient funds" will be charged a minimum \$25.00 service fee.

Patient is responsible for any attorney fees incurred during collections of past due amounts.

Signature

Date

Minors:

Adult patients are responsible for full payment at time of service. The adult accompanying a minor is responsible for payment. This office will not bill a non-custodial parent for services delivered to a minor. For unaccompanied minors, treatment may be denied unless charges have been pre-approved to a credit card or other payment arrangements have been made.

Initial

Consent for Treatment:

Patient Name _____

First

Last

I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the dental needs of the above named patient. Upon such diagnosis, I authorize the doctor or designated staff to perform all recommended treatment mutually agreed upon by us and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives, and other medications 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 have read, understood and agree to the above treatment policy.

Carnes Family Dental

Payment Plan Options:

____ Pay in full day of service with Card, Cash or Check

____ Care Credit – no interest payment plan – 6 or 12 months same as cash through an outside company
(Ask us for more information)

Tell us where you heard about us:

- Friend or Relative - Who was it? We want to say thanks _____
- Insurance Company
- Facebook
- Google Search
- Our Website
- Search Engine
- Saw our office

HIPPA:

I have been informed and given the right to review and secure a copy of your NOTICE of PRIVACY PRACTICES, which contains detailed description of th uses and disclosures to protect my personal health information and my rights under HIPPA.

Signature Required

Date

Authorization:

All of the above information is correct to the best of my knowledge. I authorize use of this form on all my insurance submissions and I authorize the release of information to all my insurance companies. I understand that I am responsible for my bill. I authorize Carnes Family Dental to act as my agent in helping me to obtain payment from my insurance company. I authorize Carnes Family Dental, its employees, and/or other agents' express prior consent to contact me at any/all phone numbers listed or by email for purposes necessary.

Signature required

Date

Missed or Canceled Appointment Policy

We want to thank you for choosing us as your dental health provider. In order to provide you and other patients with the best optimal dental care, we request that you follow our guidelines regarding missed and/or canceled appointments.

Please remember we have reserved appointment times especially for you. We make every effort to give you several reminders prior to your appointment so that if you have an unavoidable scheduling conflict, we can give that time to another patient in a timely manner.

We realize your time is important as well. We request at least **24 hours' notice** to avoid any cancellation fees. This will enable us to offer your canceled time to other patients that desire to get their treatment completed. If we know ahead of time that you can't make your appointment, it's optimal to reschedule so that someone else can have your previously scheduled appointment time.

Any appointment not canceled or changed within **24 hours** is considered a broken appointment. We charge **\$50 per broken appointment**. Patients who chronically break their appointments may be put on a call list or dismissed from the practice.

Signature

Date