New Patient Registration

Today's Date _____

First Name: _____ MI _____ Last Name: _____

Preferred Name: _____ DOB _____ Age: _____

SS # _____ Home # _____ Cell #_____ Work # _____

Address: _____

City: _____ State _____ Zip: _____

Employer: _____ Occupation: _____

Referred By: _____ Emergency Contact: _____ Phone Number:_____

Responsible Party

First Name: _____ MI _____ Last Name: _____

DOB _____ Age: _____ SS # _____

Home #_____ Cell #_____ Work # _____

Employer: _____ Occupation: _____

Primary Dental Insurance (Please present cards to scan)

Insurance Co. Name: _____Policy # _____

Policy Owner's Name: _____Relationship to Patient: _____

Policy Owner's DOB: _____ SS # _____ Employer: _____

Does Patient have dual coverage? ☐ Yes ☐ No

Secondary Dental Insurance

Insurance Co. Name: _____Policy # _____

Policy Owner's Name: _____Relationship to Patient: _____

Policy Owner's DOB: _____ SS # _____ Employer: _____

Medical History

Are you currently under the care of a physician? ☐ Yes ☐ No If yes, Explain:

_____

_____

Name of Physician, Address, and Phone Number: _____

_____

Please list ALL allergies to drugs, food, dye, etc. _____

_____

_____

Please list your current medications: _____

_____

_____

Please check the box that applies to you:

☐ Artificial Limb/Joint/Hip	☐ Anemia	☐ Alzheimer's/Dementia
☐ Anxiety	☐ Asthma	☐ Acid Reflux
☐ Arthritis	☐ ADD/ADHD	☐ Blood Thinner
☐ Blood Disorder	☐ Cancer	☐ Chemotherapy Tx
☐ COPD	☐ Diabetes	☐ Dizziness/Fainting Spells
☐ Depression	☐ Drug Dependency	☐ Epilepsy/Seizures
☐ Excessive Bleeding	☐ Fever Blisters	☐ Fibromyalgia
☐ Glaucoma	☐ Head Injury	☐ Heart Murmur
☐ Heart Disease	☐ HIV/AIDS	☐ High/Low Blood Pressure
☐ High Cholesterol	☐ Hepatitis: A or B or C	☐ Hormone Therapy
☐ Jaundice	☐ Kidney Problems	☐ Liver Problems
☐ Migraines	☐ Mitral Valve Prolapse	☐ Mouth Ulcers
☐ Nervous Disorder	☐ Osteoporosis	☐ Organ Transplant
☐ Pacemaker	☐ Pregnancy	☐ Psychiatric/Emotional
☐ Prolonged Bleeding	☐ Radiation Therapy	☐ Respiratory Problems
☐ Rheumatic Fever	☐ Sinus Problems	☐ Stents
☐ Stroke	☐ Stomach Problems	☐ STD
☐ Thyroid Problems	☐ Tuberculosis	☐ TMJ Problems

Have you been told that you snore in your sleep? ☐ Yes ☐ No

Have you ever been diagnosed with Sleep Apnea? ☐ Yes ☐ No If yes, please answer the following.

Have you ever been prescribed a CPAP? ☐ Yes ☐ No

Do you currently use a CPAP? ☐ Yes ☐ No

Who is your Sleep Physician? _____

If you have any questions about our treatment options for Sleep Apnea, please feel free to ask any of our Hygienist or Doctors.

_____ _____

Patient or Responsible Party Signature Date

Financial Policy

Thank you for choosing our practice to serve your dental needs. Please take the time to read the following, initial each section, and sign and date the bottom of this form.

Initial

_____ Full payment is due at the time of service unless arrangements have been made prior to the start of any treatment. We accept cash, checks, Care Credit, VISA, Mastercard, Discover, and American Express.

_____ Insurance balances are ultimately the patient's obligation. We will file most primary insurances at no cost to you as a courtesy. However, insurance balances which are not paid within 60 days may be billed to you. Please keep up with your statements and follow up with your insurance carrier to ensure prompt payment.

_____ Some of your treatment may <u>not</u> be covered by your insurance carrier. The cost for such charges will be your responsibility.

_____ The parent or guardian who brings a child for their initial visit is responsible for payment independent of what a divorce decree may state. Reimbursement must be between the divorced parents. We will not intervene.

_____ There will be a $35 service charge for all returned checks.

_____ Broken appointments represent a cost to us, to you, and to other patients that could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment. Excessive abuse of scheduled appointments may result in discharge from the practice.

I have read and understood the Terrace Hill Dental Center Policy. I agree to assign insurance benefits to Terrace Hill Dental Center, PLLC, whenever necessary. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for a collections fee of 25% of the amount owed.

_____ _____

Patient or Responsible Party Signature Date

_____ _____

Print Name Witnessed By

Patient Consent to Receive Mail, E-mail, and/or Telephone Messages

_____

Please print (Last Name) (First Name) (M.I)

I agree that the practice may communicate with me electronically at the following address:

_____ _____

Phone Number Email Address (*please print)*

I consent to receive calls and text messages related to my protected healthcare and other services at the phone number(s) above, including my wireless number provided. I understand I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system.

Do we have permission to:

Send a recall appointment reminder to your home: Y _____ N _____

Leave appointment, billing, or dental information
on your answering machine/voice mail/e-mail: Y _____ N _____

I give my permission to share appointment, billing, or dental information with the person(s) named below:

Name(s): _____

_____ _____

Signature of Patient/Parent or Legal Guardian Date

If signed by other than patient, specify relationship to patient: _____

Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy of this office's Notice of Privacy Practices.

_____ _____

Signature of Patient/Parent or Legal Guardian Date