Patient Registration

Patient Information **Today's Date: _______________**

Name: Last_____________________________ **First** _______________________________**MI**______

Marital Status: Single Married Divorced Widowed Minor Sex: Male Female

Address: ____

City, State, Zip: ____

Telephone #: Work ________________ Home __________________ Mobile/Pager _____________

Birthdate: ____________ Age: _____ Social Security Number: ___________________________

How did you hear about us? ____

Has any member of your family ever been treated here/Who? _______________________________

Employer: _____________________ E-Mail Address:______________________________________

Person Financially Responsible For Account

Name: Last_____________________________ **First** _______________________________**MI**______

Marital Status: Single Married Divorced Widowed Sex: Male Female

Address: ____

City, State, Zip: ____

Telephone #: Work ________________ Home __________________ Mobile/Pager _____________

Birthdate: ____________ Age: _____ Social Security Number: ___________________________

Relation to Patient: _____________________________ Is this Person a Patient in our Office? Y N

Dental Insurance Information (Primary)

Insured's Name: ________________________________ Insured's SSN: ______________________

Insured's Birthday: __________________ Number of years employed: _________

Employer: ____ Position: _______________________

Dental Insurance Company: ____________________________ Group #: ________ Local #: ______

Insurance Company Address: ____

Insurance Company Telephone #: ____________________________

Employer Contact Person and Phone Number: ____

Dental Insurance Information (Secondary)

Insured's Name: ________________________________ Insured's SSN: ______________________

Insured's Birthday: __________________ Number of years employed: _________

Employer: ____ Position: _______________________

Dental Insurance Company: ____________________________ Group #: ________ Local #: ______

Insurance Company Address: ____

Insurance Company Telephone #: ____________________________

Employer Contact Person and Phone Number: ____

Emergency Information:

Person to Contact in Case of Emergency: ____

Relationship: _______________________ Telephone Number: _____________________

I authorize doctor or designated staff to take x-rays and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis. I authorize doctor to perform all recommended treatment mutually agreed upon by me with any needed anesthetics and materials. I agree to be responsible for payment of all services rendered on my behalf and on my dependents and that such payments are due at time of services unless other arrangements have been made.

Patient's or Responsible Party Signature: ____________________________________ Date: ______________

Medical and Dental History

Dental History

Patient Name: ______________________________

Purpose of today's visit: ______________________________
Date of last dental visit: ______________ Last cleaning: ____________ Last X-Rays: ______________
How often do you Brush/Floss: ______________________ Have you ever had braces? Yes No
Have you ever had gum surgery or treatment? Yes No When/Where? ______________________
Are you nervous about dental treatment? Yes No Would you consider Nitrous Oxide Gas or Mild Sedatives? Yes No
Have you had Jaw/TMJ pain? Yes No Please Describe: ______________________
Are you interested in Teeth Whitening? Yes No Do your parents wear dentures? Yes No
Name of Previous General Dentist: ______________________

Medical History

Do you have any Current Health Problems? Yes No Please explain: ______________________
____
Are you under a Physician's Care now? Yes No Please explain: ______________________
____
List All Medications are you currently taking and the medical reason why you are taking each: ______________
____
____
____
Have you been hospitalized in the last 2 years? Yes No Please explain: ______________________
Do you Smoke or Chew Tobacco? Yes No
(WOMEN):
Are you Pregnant? Yes No Are you Nursing? Yes No Are you taking Birth Control Pills? Yes No

Indicate Which of The Following You Have Had Or Have At Present. **Circle YES or NO to each item**

Heart attack/Disease…………Yes No	AIDS………………………....Yes No	Drug Addiction……….……...Yes No
Angina Pectoris………………Yes No	HIV positive…………………Yes No	Psychiatric Care……………...Yes No
Congenital Heart Lesions…… Yes No	Blood Transfusion…………...Yes No	Nervousness…………………Yes No
High blood pressure…………Yes No	Hepatitis…………………..….Yes No	Alcoholism…………………...Yes No
Rheumatic Fever……………..Yes No	Hemophilia…………………..…Yes No	Asthma………………………Yes No
Mitral Valve Prolapse………..Yes No	Anemia………………………Yes No	Sinus Trouble………………...Yes No
Artificial Heart Valve…..……Yes No	Do you Bruise Easily………...Yes No	Hay Fever……………………Yes No
Heart Pacemaker……………..Yes No	Bleeding Problems………..…Yes No	Allergies/Hives….…………....Yes No
Heart surgery…………………Yes No	Kidney Trouble……………....Yes No	Fainting/Dizzy Spells………...Yes No
Chest Pain…………………....Yes No	Ulcers………………………...Yes No	Neurological Disorders…..….Yes No
Swollen Ankles…………...….Yes No	Epilepsy/Seizures……………Yes No	Arthritis/Rheumatism………...Yes No
Artificial Joints (Hip, Knee)…Yes No	Chemotherapy………………..Yes No	Cortisone Medicine…………..Yes No
Stroke………………………...Yes No	Radiation Treatment…………Yes No	Pain in Jaw Joint/TMJ……….Yes No
Diabetes……………………...Yes No	Tumors/Cancer………………Yes No	Fever Blisters/Cold Sores…….Yes No
Thyroid Disease…………..….Yes No	Gag Reflex…….……………..Yes No	Cosmetic Surgery……………Yes No

Are You Allergic To Or Have You Reacted Adversely To Any Of The Following Medications? **Circle YES or NO**

Aspirin………………………..Yes No	Codeine………………………Yes No	Penicillin……………………..Yes No
Local Anesthetic………………Yes No	Nitrous Oxide…………………Yes No	Erythromycin…………………Yes No
Sulfa Allergy…………………..Yes No	Vicodin/Vicoprofen Allergy….Yes No	Latex Allergy…………………Yes No
Acetaminophen………………..Yes No	Demerol………………………Yes No	Flonase………………………Yes No

List any other Medications you may be Allergic to:______________________________

I understand that I am to report any and all changes in my medical condition or medications

Signature ______________________________ Date ______________

THE FOLLOWING APPLIES TO THOSE WITH DENTAL INSURANCE ONLY

It is the Patient's sole responsibility to pay for all services in full. As a courtesy, once your insurance has been verified, we will accept assignment of benefits on your primary insurance providing you understand and agree to the following:

Your insurance is a contract between **you**, **your employer**, and **the insurance company**. We are not a party to that contract, nor can we become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, or usual and customary charges, etc. We can assist in creating a pre-estimate for the insurance company that may give a more precise estimate of their payments although, insurance companies usually take anywhere from 2-6 weeks to return a pre-estimate.

We will discuss the **estimated** insurance payment and your estimated co-payment.

You must understand that this is only an estimate.

Your exact share will not be known until the insurance payment is received and it is impossible for our staff to know every detail of each insurance plan. It is the Patient's **sole** responsibility to know any exclusions or reasons for non-payment on their insurance plan. We are not responsible for tracking benefits remaining. You will be asked to pay your estimated portion including insurance deductibles at the time of service.

State law requires insurance companies pay claims within 30 days of being submitted. **If your insurance company does not pay within 60 days, then all charges become due from you.** We will assist you in dealing with your insurance company, however the ultimate responsibility lies with you for the services you received.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize and request my insurance company to pay directly to Randall Klint, DDS the amount due on my claim for services rendered to me or my dependent.

Signed ____ Date ________________

Patient/Parent/Legal Guardian

FACTS YOU SHOULD KNOW
ABOUT DENTAL INSURANCE

As an optimum care dental practice, we strongly believe our patients deserve the best possible dental services we can provide. In an effort to maintain our high quality of care, we would like to share some facts about dental insurance with you.

Fact #1: Your dental insurance is based upon a contract made between your employer and an insurance company. Should questions arise regarding your dental insurance benefits, it is best for you to contact your employer or insurance company directly.

Fact #2: Dental insurance benefits differ greatly from general health insurance benefits. In 1971 your dental insurance benefits were approximately $1000 per year. Some 3 decades later, you will note that your benefits are often still around $1000 per year. Figuring a 6% rate of inflation per year, you should be receiving approximately $5000 per year in dental benefits. Your premiums have increased, but your benefits have not. Therefore, dental insurance is never a pay-all; it is only a supplement.

Fact #3: You may receive notification from your insurance company stating that dental fees are “higher than usual and customary”. An insurance company surveys a geographic area, calculates an average fee, takes 80% of that fee and considers it customary. Included in this survey are discount dental clinics and managed care facilities, which bring down the average. The fees that service doctors in private practice will have are fees that insurance companies often define as higher than “usual and customary”.

Fact #4: Many plans tell their participants that they will be covered “up to 80% or up to 100%” but do not clearly specify plan fee schedule allowance, annual maximum or limitations. It is more realistic to expect dental insurance to cover 35% TO 65% of major services. Remember, the amount a plan pays is determined by how much the employer paid for the plan. You get back only what your employer put in, less the profits of the insurance company.

Fact #5: Many routine dental services are NOT covered by insurance companies. Some dental plans have 80+ page manuals that detail exclusions and limitations, making it virtually impossible for most dental offices and patients to know exact coverage.

Financial arrangements must be made directly with us regardless of insurance coverage. You will need to file a claim form with your insurance company for receipt of benefits. Our office will assist you in filing your claim form.

Please do not hesitate to ask us any questions about our office policies. If you have a question regarding your insurance benefits, contact your employer or insurance carrier directly.