MODERN DENTISTRY
Comprehensive • Implant • Sedation

Patient Registration

Today's Date _____/_____/20_____ (Please Print)

PATIENT INFORMATION

Patient's Last Name	First	Middle	❑ Mr. ❑ Mrs.	❑ Ms. ❑ Dr.	Marital Status (Circle One) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	How should we address you?	Birth Date / /	Age	Sex ❑M ❑ F

Street Address	Social Security No.	Home Phone No. ( )

City	State	ZIP Code	Years at this address	E-mail Address

Occupation	Employer	Years with this employer	Employer Phone No. ( )

Who may we thank for referring you? ❑ Friend _____ ❑ Family _____
❑ Newspaper _____ ❑ Radio ❑ Sign ❑ Yellow Pages ❑ Dr. _____ ❑ Other _____

Other Family Members Seen Here_____

ACCOUNT AND INSURANCE INFORMATION (Please give your insurance card to the receptionist)

Person responsible for services ❑ Self ❑_____	Birth Date / /	Street Address
Is this person a patient here? ❑ Yes ❑ No	Home Phone No. ( )	City State ZIP Code

Occupation	Employer	Employer Address	City	State	ZIP Code	Employer Phone No. ( )

Is this person covered by dental insurance? ❑ Yes ❑ No	Insurance Company	Subscriber S. S. No.	Group No.	Policy No.	Deductible $
Primary Policy Holder's Name	Insurance Phone No. ( )	Insurance Address	City	State	ZIP Code

Patient's Relationship to Primary Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other

Is this person covered by a second dental insurance? ❑ Yes ❑ No	Insurance Company	Subscriber S. S. No.	Group No.	Policy No.	Deductible $
Secondary Policy Holder's Name	Insurance Phone No. ( )	Insurance Address	City	State	ZIP Code

Patient's Relationship to Secondary Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other _____

All the information on this form is true to the best of my knowledge. I hereby authorize the release of any information including the diagnosis and the records of any treatment or examinations rendered to my insurance company or companies. This release is solely for the purpose of facilitating the billing and reimbursement, directly to the dentist, of insurance benefits to which I am entitled. I understand that payment is due at the time of services. I agree to pay for any balances that are not paid for by my insurance policy 30 days after services have been rendered to me. I agree that any balances which exceed 30 days from the date of service may be subject to a 1.5% monthly finance charge (18% annually). In the event of default, I (we) promise to pay interest on the indebtedness, together with reasonable attorney fees, an additional 50% of the balance added for collection costs, and any other costs that will be required to effect collection of this account. I understand that failing to pay my balances to Modern Dentistry is a sufficient reason for dismissal as a patient of record.

Signature of Patient / Parent / Guardian	Signature of Account Holder
Signature of Primary Insurance Holder	Signature of Secondary Insurance Holder

IN CASE OF EMERGENCY

Name of local friend or relative (not living at the same address)	Relationship to Patient	Home Phone No. ( )	Work Phone No. ( )

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Financial Agreement

All patients, please read the following…

Payment for services is expected at the time service is provided. Cash and personal checks are accepted. Visa, MasterCard, and Discover are also accepted. If an extended payment plan is desired, please ask us about our financing programs. If you have any questions, feel free to ask.

I understand and agree that if I miss any scheduled appointment without providing at least 48 hours notice, except in extenuating circumstances as determined by this dental office, I will be charged a "no show" fee of $50. This would be no different than if I had failed to show up to a hotel or airplane flight. I understand that this charge will not be able to compensate the doctor and his staff fully for their time and money, and I agree that this charge is fair and reasonable. **In addition, if I am more than 15 minutes late to an appointment, this dental office may reschedule my appointment and charge me a fee of $50**. I understand that my tardiness may result in the excessive waiting of other patients, and that both rescheduling my appointment and the late fee are reasonable and appropriate.

I understand and agree that all services rendered me, my dependents, or others assigned by me to my account are charged directly to me. I further understand I am personally responsible for payment. If I suspend or terminate care and treatment, any fees for services rendered will be immediately due and payable. Should the fees for the professional services not be paid in accordance with the provisions herein, reasonable attorney's fees, plus applicable finance charges and disbursements, allowances and costs provided by law shall be included in the computation of the amount due. Finance charges can be applied to all amounts that are at least 30 days past due at the rate of 1.5% per month (18% annual rate). If the account is in default and turned over for collection, a 50% collection fee and other costs associated with effecting collections will be added.

If you have dental insurance…

As a courtesy, we will file your claim for you. We accept direct payment from most insurance companies. We will estimate your deductible and the portion not covered by your insurance, which is due at the time of treatment. Our estimates may be different than your insurance company's calculations; therefore, the amount due our office may be adjusted accordingly. You may find that our fees may be different from the insurance company's schedule of "allowable" or "UCR" fees. If you have questions about "UCR" fees, please feel free to ask. **All services rendered are charged directly to the patient, and the patient is ultimately responsible for the account regardless of insurance coverage**. Any insurance claims denied or remaining unpaid after 30 days may automatically become the responsibility of the patient. By signing below, I signify that I have read, understand, and agree to each paragraph and provision of this financial agreement:

_____ _____

Print Name Signature & Date

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Medical History

Chart #: _____

Name: _____ Date: _____/_____/20_____ Age: _____

1. Why are you here today? _____

❑ Yes ❑ No 2. Are you having pain or discomfort at this time? Where? _____
How Long? _____ What makes it worse? _____

❑ Yes ❑ No 3. Do you feel very nervous about having dental treatment? Why?_____
_____

❑ Yes ❑ No 4. Have you ever had a bad experience in the dental office? Please explain. _____
_____

❑ Yes ❑ No 5. Are you dissatisfied with the appearance of your teeth?

❑ Yes ❑ No 6. Have you been under the care of a medical doctor during the past two years?
Regular Physician's Name _____
Address _____ Phone _____

❑ Yes ❑ No 7. Are you currently taking any medications or drugs, including herbals?
If yes, please list ALL of them: _____
_____
_____

❑ Yes ❑ No 8. Have you been a patient in the hospital during the past two years?

❑ Yes ❑ No 9. Have you had surgery in the past two years? What kind? _____
Were there any complications? ❑ Yes ❑ No

❑ Yes ❑ No 10. Are you allergic to any of the following? Please check all that apply.

❑ Aspirin	❑ Nitrous Oxide	❑ Valium	❑ Penicillin
❑ Darvocet	❑ Erythromycin	❑ Latex	❑ Sulfites
❑ Codeine	❑ Local Anesthetics	❑ Tetracycline	❑ Amoxicillin
❑ Vicodin	❑ Nembutal/Seconal (sleeping pills)	❑ Other antibiotics: _____	

❑ Yes ❑ No 11. Are you aware of being allergic to ***any other*** medication, metal, or substance?
If yes, please list them: _____

❑ Yes ❑ No 12. Do you require pre-medication? ❑ I'm not sure

❑ Yes ❑ No 13. Please **check** any of the following conditions which you have had or currently have. Please review this list carefully since your health and optimal treatment outcome may depend on your responses.

❑ Artificial heart valve	❑ Congenital heart defect	❑ Heart murmur
❑ Rheumatic heart disease	❑ Bacterial endocarditis	❑ Mitral valve prolapse
❑ Artificial joints (Date of placement: _____ / _____ / _____)		
❑ Heart surgery	❑ Heart failure	❑ Angina Pectoris
❑ Heart Disease or Attack	❑ Heart pacemaker	❑ Stroke
❑ Narrow Angle Glaucoma	❑ Thyroid disease	❑ Pain in jaw joints
❑ Liver disease	❑ Hepatitis (Type ____)	❑ Abnormal bleeding
❑ Hemophilia	❑ Anemia	❑ Bruise easily
❑ High blood pressure (Controlled blood pressure: _____ / _____)		
❑ Fainting or dizzy spells	❑ Frequent headaches	❑ Epilepsy or Seizures
❑ Emphysema	❑ Persistent cough	❑ Allergies or hives
❑ Tuberculosis (TB)	❑ Hay fever	❑ Sinus trouble
❑ Asthma (Inhaler? ❑ Yes ❑ No; Last episode: _____ / _____ / _____)		
❑ Kidney trouble ❑ Diabetes (Type ❑ I ❑ II; Last Reading: _____)		
❑ Cortisone therapy	❑ Arthritis	❑ Drug addiction
❑ Chemotherapy	❑ Radiation Therapy	❑ Cancer
❑ Difficulty swallowing	❑ Severe gag reflex	❑ Ulcers
❑ HIV or AIDS	❑ Prolonged infections	❑ Psychiatric treatment
❑ Other: _____		

Notes

Continued on the next page

❑ Yes ❑ No 14. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest or shortness of breath, or because you are very tired?

❑ Yes ❑ No 15. Do you snore? How do you know? _____

❑ Yes ❑ No 16. Do you smoke or use smokeless tobacco?
If yes, how many packs do you smoke per day? _____
How many years have you smoked? _____

❑ Yes ❑ No 17. Do you drink soda/pop/sweetened carbonated beverages?
If yes, how may cans or servings per day? _____

❑ Yes ❑ No 18. Do you drink sweetened beverages such as coffee, tea, fruit juices (Snapple, etc.), or sports drinks (Gatorade, etc.)
If yes, how may cups or servings per day? _____

❑ Yes ❑ No 19. Do you eat candy/donuts/sugary foods?
❑ As part of or near my meals ❑ As a snack

❑ Yes ❑ No 20. Have you ever had ❑ Braces ❑ Gum Disease ❑ Periodontal Surgery
❑ Dental Implants ❑ Jaw Surgery ❑ Removal of Wisdom Teeth
Were there any complications? _____

❑ Yes ❑ No 21. Do you wake up with soreness/stiffness/pain in your face or upper neck?

❑ Yes ❑ No 22. Do you wake up with headaches?

❑ Yes ❑ No 23. Do you have a stressful day or job?

❑ Yes ❑ No 24. Do you chew gum? ❑ < 1hour/day ❑ > 1 hour/day

❑ Yes ❑ No 25. Have you had teeth, fillings, or crowns fall out, break, or chip in your mouth?

❑ Yes ❑ No 26. Does you jaw click or hurt when you chew?

❑ Yes ❑ No 27. Do you have fluoride in your water? ❑ I'm not sure

24. When was your last dental exam? ____/____/____ X-rays? ____/____/____

25. When was your last dental cleaning? ____/____/____

26. Times a day you brush? _____ Times a week you floss? _____

27. When do you brush your teeth? ❑ Morning ❑ Evening

28. When do you floss your teeth? ❑ Morning ❑ Evening

29. Do you have bad breath? ❑ Morning ❑ Noon ❑ Evening ❑ Bedtime

❑ Yes ❑ No 30. Do you use an electric tooth brush?

❑ Yes ❑ No 31. Do you use a tongue scraper?

FOR WOMEN ONLY:

Are you pregnant? ❑ Yes ❑ No If yes, what month? _____

Are you taking birth control pills? ❑ Yes ❑ No

Notes

_____

Medical Consult Needed:

❑ Blood test
❑ Blood thinner
❑ High BP
❑ High blood sugar
❑ SBE Prophylaxis
❑ Sedation
❑ Suspicious lesion
❑ Tonsils
❑ Other: _____

To the best of my knowledge, all of the preceding answers are true and correct. I understand that this information will be held in confidence and will be used only to improve communication and treatment selection between my doctor and me. If I have any changes, I will be sure to update my medical history at the next appointment.

I hereby authorize the doctor to take any diagnostic records deemed necessary to make a thorough diagnosis of my dental needs and to perform any and all forms of treatment and therapy agreed upon by me.

_____ _____/_____/20_____
Patient's signature Date

_____ _____/_____/20_____
Signature of parent or legal guardian (please circle one) Date

Reviewed by Doctor _____ _____/_____/20_____

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PLEASE ANSWER ALL QUESTIONS

" Tell me about your past experiences with dentists. Is there anything we should try to repeat or avoid?
_____
_____
_____

" What was your best dental experience and why was it good for you? _____
_____
_____

" Would you please describe for me what you think a good dentist is like? _____
_____

" If you had a magic wand, what would you change about your smile? _____
_____

" How would you like your teeth to be 15 years from now? _____
_____

" On a scale of 1 to 10, how do you feel about the condition of your mouth?
Terrible 1 2 3 4 5 6 7 8 9 10 *Perfect* *(please circle)*

" On a scale of 1 to 10, how would you like it to be?
Terrible 1 2 3 4 5 6 7 8 9 10 *Perfect* *(please circle)*

" What is the most important thing to you about your teeth? _____
_____

" What is your primary dental concern? _____
_____

" What is the history of your family members' (parents, grandparents, etc.) teeth? Did they have partial or full dentures? _____
_____

" What kind of role will insurance have in achieving your objectives?
No Role Minor Role Moderate Role Major Role *(please circle one)*

" Have you thought about a budget for your dental treatment? _____
_____

" In our work together, what would you like to accomplish (goals)? _____
_____
_____

" Is there anything happening in your life that could influence treatment? _____
_____

" Is the timing right for you to have dental treatment now? _____
_____

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Photography Release

I _____, hereby authorize the doctor and staff of Modern Dentistry to take photographs, slides, and / or videos of my face, jaws, and teeth.

I understand that the photographs, slides, and / or videos will be used as a record of my care and for professional communications with other doctors, dental laboratories, or other professionals involved with my care.

I understand that these pictures may be used for educational purposes in lectures, demonstrations, advertising (including website publication, newspapers, magazines, phone books, television), and professional publications (dental magazines and journals).

I further understand that if the photographs, slides, and / or videos are used in any publication or as a part of a demonstration, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs.

_____ _____

Signature Date

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About our fees…

Dear Patient,

Your fee is based on the time we spend with you during your visit, the complexity of your dental and medical conditions, and any treatment we provide. However, proper attention to your care also requires that we as a dental team, spend additional time beyond that which we spend with you in the office. Such time may be used to:

- Create and maintain your permanent dental record.
- Clean our rooms, equipment, and sterilize our instruments.
- Stock materials and supplies to be used in your care.
- Attend modern continuing education programs to offer you the latest and best that dentistry has to offer.
- Review, compare, and file current and previous radiographs.
- Prepare and mail recall appointment reminders.
- Consult via phone about your case with relevant health care providers.
- Prepare referral letters to additional specialists, as needed.
- Prepare patient educational materials.
- Conduct dental and medical research relevant to your case.
- Communicate with pharmacies about your prescriptions.
- Complete and mail insurance applications and claim forms.
- Conduct utilization review negotiations with insurance companies.
- Comply with government and licensing regulations and requirements.
- Perform business duties necessary to provide you with optimal service.

All these activities add to our cost of doing business above and beyond the normal overhead that all businesses must pay for. Still, we are committed to providing you the best possible care at a fair cost. We hope this explanation of our fees has been helpful. With you, our patient, we look forward to a lasting and healthy relationship.

Sincerely,

The Modern Dentistry Team