DENTAL REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____

Patient _____

Address _____

_____
City State Zip

Sex: ❑ M ❑ F Age _____ Birthdate _____

❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Patient SS# _____

Occupation _____

Employer _____

Employer Address _____

Employer Phone _____

Spouse's Name _____

Birthdate _____ SS# _____

Occupation _____

Spouse's Employer _____

Whom may we thank for referring you? _____

_____

2 DENTAL INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ❑ Yes ❑ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Responsible Party Signature

_____ _____
Relationship Date

3 PHONE NUMBERS

Home _____ Work _____ Cell _____

E-Mail _____ Best time to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home Phone _____ Work/Cell Phone _____

4 DENTAL HISTORY

Reason for today's visit _____

_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

Check "Yes" or "No" where indicated for all that apply:

Would you like whiter teeth?	❑ Yes	❑ No
Bad breath	❑ Yes	❑ No
Bleeding gums	❑ Yes	❑ No
Blisters on lips or mouth	❑ Yes	❑ No
Burning sensation on tongue	❑ Yes	❑ No
Chew on one side of mouth	❑ Yes	❑ No
Cigarette, pipe, or cigar smoking	❑ Yes	❑ No
Clicking or popping jaw	❑ Yes	❑ No
Dry mouth	❑ Yes	❑ No
Fingernail biting	❑ Yes	❑ No
Food collection between the teeth	❑ Yes	❑ No
Foreign objects	❑ Yes	❑ No
Grinding teeth	❑ Yes	❑ No
Gums swollen or tender	❑ Yes	❑ No
Jaw Pain or tiredness	❑ Yes	❑ No
Lip or cheek biting	❑ Yes	❑ No
Loose teeth or broken filings	❑ Yes	❑ No
Mouth breathing	❑ Yes	❑ No
Mouth pain, brushing	❑ Yes	❑ No
Orthodontic treatment	❑ Yes	❑ No
Pain around ear	❑ Yes	❑ No
Periodontal treatment	❑ Yes	❑ No
Sensitivity to cold	❑ Yes	❑ No
Sensitivity to heat	❑ Yes	❑ No
Sensitivity to sweets	❑ Yes	❑ No
Sensitivity when biting	❑ Yes	❑ No
Sores or growths in mouth	❑ Yes	❑ No

How often to you floss? _____

How often do you brush? _____

– OVER –

5 HEALTH HISTORY

Physician's Name _____ Date of last visit _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS	❑ Yes ❑ No	Emphysema	❑ Yes ❑ No	Psychiatric Care	❑ Yes ❑ No
Alzheimers	❑ Yes ❑ No	Epilepsy	❑ Yes ❑ No	Radiation Treatment	❑ Yes ❑ No
Anemia	❑ Yes ❑ No	Fainting or dizziness	❑ Yes ❑ No	Respiratory Disease	❑ Yes ❑ No
Arthritis, Rheumatism	❑ Yes ❑ No	Glaucoma	❑ Yes ❑ No	Rheumatic Fever	❑ Yes ❑ No
Artificial Heart Valves	❑ Yes ❑ No	Headaches	❑ Yes ❑ No	Scarlet Fever	❑ Yes ❑ No
Artificial Joints	❑ Yes ❑ No	Heart Murmur	❑ Yes ❑ No	Shortness of Breath	❑ Yes ❑ No
Asthma	❑ Yes ❑ No	Heart Problems	❑ Yes ❑ No	Sinus Trouble	❑ Yes ❑ No
Back Problems	❑ Yes ❑ No	Hepatitis (Type _____)	❑ Yes ❑ No	Skin Rash	❑ Yes ❑ No
Bleeding abnormally, with extraction or surgery	❑ Yes ❑ No	Herpes	❑ Yes ❑ No	Special Diet	❑ Yes ❑ No
		High Blood Pressure	❑ Yes ❑ No	Stroke	❑ Yes ❑ No
Blood Disease	❑ Yes ❑ No	HIV Positive	❑ Yes ❑ No	Swelling of Feet or Ankles	❑ Yes ❑ No
Cancer	❑ Yes ❑ No	Jaundice	❑ Yes ❑ No	Swollen Neck Glands	❑ Yes ❑ No
Chemical Dependency	❑ Yes ❑ No	Jaw Pain	❑ Yes ❑ No	Thyroid Problems	❑ Yes ❑ No
Chemotherapy	❑ Yes ❑ No	Kidney Disease	❑ Yes ❑ No	Tonsillitis	❑ Yes ❑ No
Circulatory Problems	❑ Yes ❑ No	Liver Disease	❑ Yes ❑ No	Tuberculosis	❑ Yes ❑ No
Congenital Heart Lesions	❑ Yes ❑ No	Low Blood Pressure	❑ Yes ❑ No	Tumor or growth on head or neck	❑ Yes ❑ No
Cortisone Treatments	❑ Yes ❑ No	Mitral Valve Prolapse	❑ Yes ❑ No		
Cough, persistent or bloody	❑ Yes ❑ No	Nervous Problems	❑ Yes ❑ No	Ulcer	❑ Yes ❑ No
Diabetes	❑ Yes ❑ No	Pacemaker	❑ Yes ❑ No	Venereal Disease	❑ Yes ❑ No

WOMEN: Are you: **Pregnant?** ❑ Yes, _____ Months ❑ No **Nursing?** ❑ Yes ❑ No **Taking birth control pills?** ❑ Yes ❑ No

MEDICATIONS

List medications you are currently taking:

_____

_____

_____

Pharmacy Name _____

Phone _____

ALLERGIES

❑ Aspirin ❑ Penicillin

❑ Barbiturates (Sleeping pills) ❑ Sulfa

❑ Codeine ❑ Other _____

❑ Iodine _____

❑ Latex _____

❑ Local Anesthetic _____

X _____

SIGNATURE OF PATIENT OR PARENT OF MINOR

6 UPDATES (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? ❑ Yes ❑ No

For what conditions? _____

Are you taking any new medications? _____ If so, what _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Has there been any change in your health since your last dental appointment? ❑ Yes ❑ No

For what conditions? _____

Are you taking any new medications? _____ If so, what _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Daniel S. Hines DDS
FINANCIAL POLICY

Welcome!. Thank you for choosing our practice to care for you !Our goal is to provide you and your family with optimal dental care. We want you to feel welcome and as comfortable as possible throughout our relationship. We encourage you to ask questions and to be involved in treatment decisions. This includes understanding your treatment plan as well as our financial policy.

Our fees are based on the quality materials we use and the time, effort, and skills required in performing your needed treatment. We charge what is the usual and customary for our area. We will assist you with you benefit and eligibility before treatment to help you calculate your cost and maximize your insurance. We will be sensitive to your financial circumstances and do everything possible to help you achieve oral health. Ultimately, however, you are responsible for payment regardless of any insurance companies' arbitrary determination of usual and customary rates.

- **Insurance information:** We are happy to submit the claims necessary to see that you receive the full benefits of your coverage; however we cannot guarantee any estimated coverage. Because the insurance policy is an agreement between you and the insurance company, we ask that all patients be directly responsible for all charges. Please know that we will do everything possible to see that you receive the full benefits of your policy by electronically filing your claim the day of your appointment. If there are any complications, we will assist with any information you may need.
- **Financial agreement:** Patients are expected to pay for our services at the time they are rendered. Our patients who have dental insurance are expected to pay the amount of their estimated co-pay and deductible at the time of service. Payments may be made using cash, check, Visa, MasterCard, American express and/or Discover. We also offer CARECREDIT and LENDING CLUB, which are financing options that are available only for healthcare expenses. We will mail monthly statements to all patients with an outstanding balance charge of 18% per APR after 90 days.
- **Payment for services is due at the time services are rendered unless prior arrangements have been made.**
- **Optional payment terms:**

  1. Full pay cash discount: We offer a 5% accounting courtesy for all services over $500 that is paid in full prior to the commencement of services.

  2. Full pay credit discount: We accept full or partial payment by Visa, MasterCard, American express or Discover. If you choose to prepay for services over $500 using your credit card, we can extend a 3% courtesy

  3. Term Loan: By arrangements with **Carecredit** and/or **Lending Club** we can offer patients upon approval, an interest-free term loan (up to 18 months) with no down payment, no annual fee and no prepayment penalty. Ask for an application.

  4.In-house monthly payments through Easy Pay using a credit card on file (Max of 4 months).

- **PDC Membership plan:**$259.99 for first family member, Additional immediate family member $159.99 (See brochure for additional information)
- Appointments: In order to serve you better and keep the cost of dental care down, we try to maintain an efficient appointment system. However, our cost of providing care increases greatly when people fail to keep scheduled appointments or cancel at the last minute. We require at least 48 hour notice for any cancelled appointment. After 3 missed appointments or cancelled appointments we will place you on a short call list, which means we will phone you when an appointment time becomes available on short notice. This gives you the opportunity to know if your busy schedule has an opening for a dental appointment within the next few hours. If proper notice is not received, a fee of $100 will be charged for every hour of allotted time cancelled to your credit card on file.
- **Deposit policy:** Due to the extensive amount of time our staff and doctors devote to preparing and reserving uninterrupted time for reservation for $200 or more, we require deposit of half of the treatment fee to make your reservation or 10% reservation.
- **Statements** :All patients with an outstanding balance will receive a statement each month. There is a charge of $5.00 on all accounts 60 days overdue. All accounts over 90 days will be subject to our collection agency. We can reserve a credit card on file balance after insurance
- **Senior citizens** (age 65+) will receive a 10% courtesy after insurance has paid. If no insurance is involved the courtesy will be immediate.

I have read and agreed to the Financial Policy and the Cancellation Policy of Premier Dental Care.

Signature of patient or Responsible Party _____

Print Name _____Date_____