## PATIENT REGISTRATION

*Please complete the following confidential information in full for optimum understanding of your dental wishes and desires. Everyone has individual needs, so we want to give you personal attention to assure you the most comfortable dental experience as possible.*

| |
|---|
| Date |
| Patient Name |
| Address |
| City State Zip |
| Best way to contact you: H W C Phone E-mail Text Message |
| Home Phone No. |
| Work Phone No. |
| Cellular Phone No. |
| E-mail Address |
| Birth date Age Male ☐ Female ☐ |
| Social Security Number |
| Married☐ Single☐ Divorced☐ Widowed☐ |
| Employer Position |
| School |

| |
|---|
| Responsible Party |
| Address |
| City State Zip |
| Responsible Party Social Security Number |

| |
|---|
| The best time for you for appointments are at: _____ AM/PM |
| The best day of the week is: M T W T R (Circle one or more) |
| Who make we thank for your referring you: |
| ☐Friend's Name |
| ☐Sign |
| ☐Website / Internet Search |
| ☐Newspaper |
| ☐Television |
| ☐Other |
| Emergency Contact Information: |
| Name |
| Relationship |
| Phone Number |
| Address |
| City State Zip |

| DENTAL INSURANCE |
|---|
| PRIMARY DENTAL CARRIER |
| Insurance Co. |
| Subscriber Birth date |
| Subscriber |
| Subscriber Employer |
| Subscriber Union or Local |
| Subscriber Social Security No. |

| SECONDARY DENTAL CARRIER |
|---|
| Insurance Co. |
| Subscriber |
| Subscriber Birth date |
| Subscriber Employer |
| Subscriber Union or Local |
| Subscriber Social Security No. |

### CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of _____'s dental needs.
(name of patient)

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents entails certain risks. I understand that I can ask for a complete recital of any possible complications.

4. Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account.

_____

Patient Date

_____

Parent of Guardian Relationship

## 4 MEDICAL HISTORY

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: _____

Phone #: (____)_____ Date of last visit: _____

**Your current physical health is:** ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: _____

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

Have you had any metal rods, pins or implants? ☐ Yes ☐ No

Are you taking any prescription / over-the-counter drugs? ☐ Yes ☐ No

Please list each one: _____

Have you ever taken Phen-Fen?
Also known as Redux or Pondimin. ☐ Yes ☐ No

If so, when? _____

**For Women:** Are you taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week #: _____

Are you nursing? ☐ Yes ☐ No

**Have you ever had any of the following diseases or medical problems**

| | | | | | |
|---|---|---|---|---|---|
| Y | N | Abnormal Bleeding / Hemophilia | Y | N | Herpes / Fever Blisters |
| Y | N | AIDS | Y | N | High Blood Pressure |
| Y | N | Alcohol / Drug Abuse | Y | N | HIV |
| Y | N | Anemia | Y | N | Hospitalized for Any Reason |
| Y | N | Arthritis | Y | N | Kidney Problems |
| Y | N | Artificial Bones / Joints / Valves | Y | N | Liver Disease |
| Y | N | Asthma | Y | N | Low Blood Pressure |
| Y | N | Blood Transfusion | Y | N | Lupus |
| Y | N | Cancer / Chemotherapy | Y | N | Mitral Valve Prolapse |
| Y | N | Colitis | Y | N | Pacemaker |
| Y | N | Congenital Heart Defect | Y | N | Psychiatric Problems |
| Y | N | Diabetes | Y | N | Radiation Treatment |
| Y | N | Difficulty Breathing | Y | N | Rheumatic / Scarlet Fever |
| Y | N | Emphysema | Y | N | Seizures |
| Y | N | Epilepsy | Y | N | Shingles |
| Y | N | Fainting Spells | Y | N | Sickle Cell Disease / Traits |
| Y | N | Frequent Headaches | Y | N | Sinus Problems |
| Y | N | Glaucoma | Y | N | Stroke |
| Y | N | Hay Fever | Y | N | Thyroid Problems |
| Y | N | Heart Attack / Surgery | Y | N | Tuberculosis (TB) |
| Y | N | Heart Murmur | Y | N | Ulcers |
| Y | N | Hepatitis | Y | N | Venereal Disease |

Please list any serious medical condition(s) that you have ever had:

_____

_____

**Are you allergic to any of the following?**

| | | | | | |
|---|---|---|---|---|---|
| Y | N | Aspirin | Y | N | Erythromycin | Y | N | Penicillin |
| Y | N | Codeine | Y | N | Jewelry/Metals | Y | N | Tetracycline |
| Y | N | Dental Anesthetics | Y | N | Latex | Y | N | Other |

Please list any other drugs/materials that you are allergic to: _____

_____

## 5 DENTAL HISTORY

**Why have you come to the dentist today?** _____

_____

Are you currently in pain? ☐ Yes ☐ No

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

**Your current dental health is:** ☐ Good ☐ Fair ☐ Poor

Have you ever had a serious / difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you floss daily? ☐ Yes ☐ No Brush daily? ☐ Yes ☐ No

Type of bristles on your toothbrush? ☐ Hard ☐ Medium ☐ Soft

Have you ever had gum treatment? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No Ever Itch? ☐ Yes ☐ No

Have you ever had periodontal disease? ☐ Yes ☐ No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐ Yes ☐ No

Are your teeth sensitive to heat, cold, or anything else? _____

Do you have any loose teeth? ☐ Yes ☐ No

Do you still have wisdom teeth? ☐ Yes ☐ No

Would you like fresher breath? ☐ Yes ☐ No Whiter teeth? ☐ Yes ☐ No

**Are you happy with the way your smile looks?** ☐ Yes ☐ No

If not, what would you change? _____

_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

_____

Signature Date

## OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical / dental information with the patient named herein.

Initials: _____ Date: _____

**Doctor's Comments:** _____

_____

_____

_____

_____

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

**MEDICAL HISTORY UPDATE**

Has there been any change in your health status since your last visit? Y N
If Yes, please explain. _____

_____ Patient Signature Date

_____ Dentist Signature Date

Has there been any change in your health status since your last visit? Y N
If Yes, please explain. _____

_____ Patient Signature Date

_____ Dentist Signature Date

**LARRY J. DIAMOND, D.D.S.**
**General Dentistry for Children and Adults**
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# OUR FINANCIAL POLICY

Payment for professional services is due at the time dental treatment is provided. Every effort will be made to provide a treatment plan which fits your timetable and budget, and gives you/and or your child the best possible care. Our office accepts cash, check, debit cards, and credit cards (Mastercard, Visa, Discover Card, and American Express). We also offer extended payment plans through Care Credit, an outside finance company (GE Money Bank).

## FOR PATIENTS WITHOUT DENTAL INSURANCE:

Non-insured patients are expected to pay in full the day service is rendered by one of the methods listed above unless specific arrangements are made in advance with our treatment coordinator.

## FOR PATIENTS WHO HAVE DENTAL INSURANCE:

1. You must provide all necessary dental insurance billing information and have coverage that allows you complete freedom of choice in selecting your dentist. (We do not participate in any Dental Maintenance Organizations.)
2. Our office accepts "assignment of benefits". This means that you must sign the portion of your insurance form that "assigns payment" directly to our office. (There are a limited number of insurance companies that do not honor the assignment of benefits. When this happens, you will be responsible for payment in full since the insurance company pays you directly.) *By law, your insurance company is required to pay each claim within 30 days of receipt.*
3. Dental insurance is meant to be an aid in receiving dental care. *No insurance pays 100% of all procedures.* The percentage paid is usually determined by how much you or your employer has paid for coverage or the type of contract your employer has purchased from the insurance company. Many patients think that their insurance pays 90%-100% of all dental fees. This is not true! Most plans only pay between 50%-80% of the average total fee. Additionally, most insurances require a deductible be paid by you one time each year per patient.
4. Many insurance companies require prior authorization of dental work in excess of a certain dollar amount before treatment can begin. If you choose to begin treatment without this predetermination of benefits/authorization, you may be responsible for the entire treatment fee. A minimum down payment of 50% of the fee will be required.

Please understand that the ultimate responsibility for payment of dental work is yours. Insurance is a third party and is not directly responsible for payment to our office. We are happy to assist you in understanding the particulars of your insurance plan. Please keep our office informed of any insurance changes such as insurance company name, address, policy number or change of employment. *Always feel free to ask any questions concerning your payments, insurance or dental treatment.* We are here to help you and to provide the highest quality in dental care.

**I have read and understand the financial policies as described above.**

X_____ Date:_____
(SIGNATURE OF PATIENT OR RESPONSIBLE PARTY )