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COSMETIC & GENERAL DENTISTRY

PATIENT REGISTRATION FORM

Date: _____ / _____ / _____

PATIENT INFORMATION		
Last name:	First Name:	Middle Name:
Date of Birth: / /	Sex (circle one): M F	Social Security #:
Marital Status (circle one): Single	Married Divorced	Separated Widowed
Mailing Address:	City:	State: Zip:
Primary Phone:	Email Address:	
Do you have dental insurance? (circle one) Yes No	If yes, name:	
Employer:		Occupation:
Emergency Contact Information	First Name:	Last Name:
	Relationship:	Phone:
Referred by?	First Name:	Last Name:
If you are completing this form for another person, what is your name and relationship to that person?		
Name:		Relationship:
If executing this form as the patient's personal representative, I represent and warrant that I have full legal right and authority to consent to the performance of any procedure(s) on this patient. If for any reason I no longer have such legal right and authority, I will immediately notify the practice in writing.		
RESPONSIBLE PARTY INFORMATION (if applicable)		
Last name:	First Name:	Middle Name:
Date of Birth: / /	Sex (circle one): M F	Social Security #:
Mailing Address:	City:	State: Zip:
Primary Phone:	Email Address:	
Employer:		Occupation:

Patient (or Responsible Party) Signature: _____ Date: _____

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PATIENT MEDICAL HISTORY FORM

Date: _____ / _____ / _____

Patient Name:			Age:		
Physician Name (and specialty, if applicable):			Phone:		
Most recent physical examination:			Purpose:		
What is your estimate of your general health? (circle one) Excellent Good Fair Poor					
DO YOU HAVE OR HAVE YOU EVER HAD:	**YES**	**NO**		**YES**	**NO**
1. Hospitalization for illness or injury If yes, explain:			12. Prolonged bleeding		
2. Allergic or bad reaction to any of the following: ☐ Aspirin, ibuprofen, acetaminophen, codeine ☐ Penicillin ☐ Erythromycin ☐ Tetracycline ☐ Sulfa ☐ Local anesthetic ☐ Fluoride ☐ Metals (nickel, gold, silver, _____) ☐ Latex ☐ Nuts ☐ Fruit ☐ Other _____			13. COPD, emphysema, or shortness of breath 14. Tuberculosis, measles, chicken pox 15. Asthma 16. Breathing or sleep problems (i.e. sleep apnea, snoring) 17. Kidney disease 18. Liver disease 19. Thyroid or parathyroid disease 20. High cholesterol 21. Diabetes (If yes, please include most recent HbA1c: _____) 22. Digestive or eating disorders (e.g., gastric reflux, anorexia, bulimia)		
3. Heart problems, or cardiac stent within the last 6 months			23. Osteopenia/osteoporosis (if yes, any history of taking bisphosphonates? _____)		
4. History of infective endocarditis			24. Arthritis		
5. Artificial heart valve, repaired heart defect			25. Autoimmune disease (i.e. rheumatoid arthritis, lupus, scleroderma)		
6. Pacemaker or implantable defibrillator			26. Glaucoma		
7. Joint replacement			27. Head or neck injuries		
8. Rheumatic or scarlet fever			28. Epilepsy, convulsions (seizures)		
9. High or low blood pressure			29. ADD/ADHD		
10. Stroke			30. Viral infections and cold sores		
11. Anemia or other blood disorder			31. Any lumps or swelling in the mouth		

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32. Hives, skin rash, hay fever			**ARE YOU:**		
33. STI/STD/HPV			41. Presently being treated for any other illness		
34. Tumor, abnormal growth			42. Aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, diarrhea)		
35. Radiation therapy			43. Taking medication for weight management		
36. Chemotherapy, immunosuppressive medication			44. Taking dietary supplements		
37. Emotional difficulties			45. Often exhausted or fatigued		
38. Psychiatric treatment			46. Experiencing frequent headaches		
39. Antidepressant medication			47. A smoker, smoked previously, or use smokeless tobacco		
40. Alcohol/recreational drug use			48. Taking birth control pills		
			49. Currently pregnant		
			50. Diagnosed with a prostate disorder		

Describe any current medical treatment, impending surgery, or other treatment that may affect your dental treatment _____

List all medications, supplements and/or vitamins taken within the last two years.			
Drug	Purpose	Drug	Purpose

I certify that I have read and answered all questions on this form to the best of my knowledge. I understand that providing inaccurate or incomplete information may affect my treatment. I agree to inform the office of any changes to my health or medical history in the future.

Patient (or Responsible Party) Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____

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PATIENT DENTAL HISTORY FORM

Date: _____ / _____ / _____

Patient Name:	Age:	
Previous Dentist:	How long were you a patient there?	
Most recent dental exam:	Date of most recent x-rays:	
Date of most recent treatment (other than a cleaning):		
I routinely see my dentist every (circle one): 3 mo. 4mo. 6mo. 12mo. Not routinely		
What is your estimate of your oral health? (circle one) Excellent Good Fair Poor		
What is your immediate concern?		
Are you experiencing any dental pain or discomfort? (circle one) Yes No If yes, where?		
PLEASE ANSWER YES OR NO TO THE FOLLOWING:	**YES**	**NO**
PERSONAL HISTORY		
1. Are you fearful of dental treatment? If yes, how fearful, on a scale from 1 (least) to 10 (most)?		
2. Have you had an unfavorable dental experience?		
3. Have you ever had complications from past dental treatment?		
4. Have you ever had trouble getting numb or had any reactions to local anesthetic?		
5. Did you ever have braces, orthodontic treatment, or had your bite adjusted? If yes, at what age?		
6. Have you had any teeth removed, missing teeth that never developed, or lost teeth due to injury or facial trauma?		
GUM AND BONE		
7. Do your gums bleed or are they painful when brushing or flossing?		
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth?		
9. Have you ever noticed an unpleasant taste or odor in your mouth?		
10. Is there anyone with a history of periodontal disease in your family?		
11. Have you ever experienced gum recession?		
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?		
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth?		
TOOTH STRUCTURE		
14. Have you had any cavities within the past 3 years?		
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?		
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?		

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17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?		
18. Do you have grooves or notches on your teeth near the gum line?		
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?		
20. Do you frequently get food caught between any teeth?		
BITE AND JAW JOINT		
21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)		
22. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?		
23. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed?		
24. Are your teeth becoming more crooked, crowded, or overlapped?		
25. Are your teeth developing spaces or becoming more loose?		
26. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?		
27. Do you clench or grind your teeth together in the daytime or make them sore?		
28. Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth?		
29. Do you wear or have you ever worn a bite appliance?		
SMILE CHARACTERISTICS		
30. Is there anything about the appearance of your teeth that you would like to change (shape, color, size)?		
31. Have you ever whitened (bleached) your teeth?		
32. Have you felt uncomfortable or self conscious about the appearance of your teeth?		
33. Have you been disappointed with the appearance of previous dental work?		

I certify that I have read and answered all questions on this form to the best of my knowledge. I understand that providing inaccurate or incomplete information may affect my treatment. I agree to inform the office of any changes to my health or medical history in the future.

Patient (or Responsible Party) Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____

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HIPAA PRIVACY PRACTICES & ACKNOWLEDGEMENT

Patient Name: _____ Date of Birth: _____

Notice of Privacy Practices

This notice describes how your health information may be used and disclosed, and how you can access this information. Please review it carefully. We are committed to protecting your privacy. The Health Insurance Portability and Accountability Act (HIPAA) requires that we provide you with this notice.

How We May Use and Disclose Your Health Information:

- **For treatment:** Sharing information with other healthcare providers involved in your care.
- **For payment:** Submitting claims to your insurance company and managing billing.
- **For healthcare operations:** Internal quality assessment, staff training, or accreditation.
- **To business associates:** We may share limited information with third-party service providers (e.g., labs, billing services), who are also required to maintain confidentiality.
- **As required by law:** Such as public health reporting, abuse reporting, or responding to subpoenas.

Your Rights:

- You may request a copy of your records.
- You may request corrections to your records.
- You may request a list of certain disclosures we've made.
- You may request restrictions on how we use or disclose your information (though we are not required to agree).
- You may request confidential communication methods (e.g., calling your cell only, not sending mail).

Our Responsibilities:

- We are required to maintain the privacy of your health information.
- We will notify you promptly if there is a breach of your unsecured health information.
- We will not use or share your information for marketing purposes without your written consent.

Acknowledgment of Receipt

I acknowledge that I have received and/or reviewed the Notice of Privacy Practices provided by this dental office. This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Patient (or Responsible Party) Signature: _____ Date: _____

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CONSENT FOR EXAMINATION & DIAGNOSTIC PROCEDURES

I authorize the dental professionals at this office to perform a comprehensive dental examination, which may include:

- A review of my medical and dental history
- A head and neck exam
- An intraoral examination of my teeth, gums, and soft tissues
- Intraoral and extraoral photographs
- Necessary radiographs (X-rays) for diagnostic purposes

I understand that this information is necessary to accurately diagnose any dental conditions and to create a proper treatment plan. I understand that I will have the opportunity to review and consent to any proposed treatment before it is performed.

I understand that withholding medical or dental information may affect the accuracy of my diagnosis and the safety of my care.

Patient name: _____

Patient (or Responsible Party) Signature: _____ Date: _____

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PHOTOGRAPH AND VIDEO CONSENT FORM

As part of your dental care, we may take photographs or videos for documentation, diagnosis, treatment planning, or educational purposes. Please read the following and indicate your preferences.

Clinical Use (Required for Documentation)

I understand that photographs or videos may be taken for:

- Treatment planning and progress tracking
- Before-and-after documentation
- Referral or communication with other healthcare providers
- Internal education and training

These images will be kept confidential and used only for professional dental purposes within the practice.

☐ I consent to the use of my images for clinical and diagnostic purposes as described above.

Marketing & Educational Use (Optional)

With your additional consent, we may use select photographs or videos (e.g., of your smile, teeth, or treatment progress) for promotional, marketing, or educational purposes, including:

- Social media (Instagram, Facebook, etc.)
- Website content
- Patient education materials or presentations

We will never use your **full face** or **name** without explicit permission.

☐ I give permission for my photos/videos to be used for marketing and educational purposes as outlined above.
☐ I do **not** give permission for any marketing or public use of my images.

Authorization & Signature

I understand that I may revoke this consent in writing at any time, but that revocation will not apply to any uses or disclosures already made in reliance on this authorization. I release the dental practice from any liability associated with the use of these images as authorized.

Patient name: _____

Patient (or Responsible Party) Signature: _____ Date: _____

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FINANCIAL POLICY & OFFICE POLICIES

Thank you for choosing our office for your dental care. We are committed to providing high-quality treatment and clear communication. Please review the following financial and office policies and sign at the bottom.

Payment Responsibility

Payment is due in full at the time of service unless prior arrangements have been made. We accept cash, credit cards, debit cards, and third-party financing solutions, such as CareCredit, Cherry, and Avvance. The person signing below is financially responsible for all treatment provided, regardless of insurance coverage

Credit Card on File

For your convenience and to streamline billing, we require a **credit or debit card to be securely stored on file** at your first visit. This card may be charged for:

- Patient balances remaining after insurance processing
- Missed or late-cancelled appointment fees (see below)
- Any charges not collected at the time of service

You will be notified before any charges are made. All card information is stored securely in compliance with data security standards.

Insurance

As a courtesy, we will file your dental insurance claims. However:

- You are responsible for knowing your insurance benefits, coverage, and limitations.
- Co-pays, deductibles, and any non-covered services are due at the time of service.
- Final financial responsibility for all services rendered lies with the patient/guarantor, regardless of insurance coverage.

We are happy to provide a written estimate before treatment, based on the information provided by your insurance company. Please note that estimates are not a guarantee of coverage.

Cancellations and Missed Appointments

Your appointment time is reserved exclusively for you. If you need to cancel or reschedule, please provide at least **24 hours' notice**.
Failure to give sufficient notice or missing an appointment entirely may result in a **fee of $50 per hour of scheduled appointment time**:

- 1-hour appointment = $50 fee
- 2-hour appointment = $100 fee, and so on

This fee cannot be billed to insurance and will be charged to the card on file.
Repeated late cancellations or missed appointments may result in dismissal from the practice or loss

Patient Initials: _____

of scheduling privileges for future appointments.

Returned Checks & Past-Due Balances

Returned checks are subject to a **$35 fee**. Balances over **30 days** past due may incur finance charges and may be referred to a collection agency after **90 days**, unless prior arrangements have been made.

Treatment Estimates

We encourage open discussion of treatment options and costs. You will receive a proposed treatment plan with estimated fees, which may change based on clinical conditions discovered during treatment. Any changes will be discussed before proceeding.

Communication Consent

By signing below, you consent to receive appointment reminders, billing notices, and treatment-related communications via phone, voicemail, email, or text message, unless otherwise requested in writing.

Acknowledgment & Agreement

I have read and understand the above financial and office policies, and I agree to their terms. I authorize the use of my credit card on file in accordance with this policy. I understand that I am financially responsible for all charges not covered by insurance.

Patient name: _____

Patient (or Responsible Party) Signature: _____ Date: _____

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CREDIT CARD AUTHORIZATION FORM

To streamline billing and provide convenience, we require a credit or debit card to be securely stored on file. Your card will only be charged under the circumstances outlined below and with prior notice whenever possible.

Authorized Uses

By signing this form, you authorize our dental office to charge your card for the following purposes:

- Patient balances remaining after insurance processing
- Missed appointment or late cancellation fees
- Charges not collected at the time of service
  Any other agreed-upon payments related to dental care

Card Information

(Please fill out or present card at the front desk — for security reasons, we do not recommend emailing this form.)

- **Cardholder Name: _____**
- **Billing Address: _____City: _____ State: ____ ZIP: _____**
- **Card Type: ☐ Visa ☐ MasterCard ☐ AmEx ☐ Discover**
- **Last 4 Digits of Card: _____**
- **Expiration Date (MM/YY): _____**
- **Phone Number: _____**

Your card will be stored securely through our payment processor in compliance with PCI (Payment Card Industry) data security standards. We do not store full card information in our office.

Authorization & Agreement

I authorize this dental office to securely store my credit/debit card and to charge it in accordance with the financial policy. I understand that I will be notified before any charges are made, and I may update or revoke this authorization at any time by submitting a written request.

Patient name: _____

Cardholder Signature: _____ Date: _____