PATIENT REGISTRATION FORM

We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form as completely as you can. If you have questions, we'll be glad to help you.

PATIENT INFORMATION

Name: ______________________ ______________ DOB: ___/___/___ SSN: ___-___-___

Last name First name Preferred

Driver's license #: ______________________ Street/mailing address: ______________________

City: ______________________ State: __________ Zip code: ______________

Billing address (If different than mailing address): ______________________

City: ______________________ State: __________ Zip code: ______________

CONTACT INFORMATION Please provide all phone numbers and emails, thank you!

Home phone: ______________ Work phone: ______________ Cell phone: ______________

Email address(s): ______________________

Employer: ______________________ Address: ______________________

Business email: ______________________ Business phone: ______________________

Best method of contact. Please check all that apply.

- ☐ Home phone
- ☐ Cell phone
- ☐ Work phone
- ☐ Personal email
- ☐ Work email
- ☐ Other: ______________

Emergency contact: ______________ Relationship to patient: ______________ Phone #: ______________

INSURANCE INFORMATION

Current dental insurance: ______________________ Insurance ID # (if applicable): ______________

Person responsible for account /primary policy holder (if other than yourself): ______________________

Birthday of primary policy holder (if other than yourself): ______________ SSN: ___-___-___

Patient Signature: ______________________ Date: ______________

HEALTH HISTORY

Patient name: ______________________ Preferred: ______________________ Age: __________

Most recently seen physician: ______________________ Specialty: ______________________

Most recent physical examination: ______________________ Purpose: ______________________

General Physician: ______________________ Address: ______________________ Phone #: __________

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU OR HAVE YOU EVER HAD:	YES	NO
1. Hospitalization for illness or injury	☐	☐
2. An allergic reaction to:		
> *Aspirin, ibuprofen, acetaminophen*	☐	☐
> *Penicillin*	☐	☐
> *Erythromycin*	☐	☐
> *Tetracycline*	☐	☐
> *Codeine*	☐	☐
> *Local Anesthetic*	☐	☐
> *Fluoride*	☐	☐
> *Metals (gold, stainless steel)*	☐	☐
> *Latex*	☐	☐
> *Any other medications:* ______________		
3. Heart problems	☐	☐
4. Heart murmur	☐	☐
5. Rheumatic fever	☐	☐
6. Scarlet fever	☐	☐
7. High Blood Pressure	☐	☐
8. Low blood pressure	☐	☐
9. A stroke	☐	☐
10. Artificial prosthesis (heart valve or joints)	☐	☐
11. Anemia or other blood disorders	☐	☐
12. Prolonged bleeding due to slight cut	☐	☐
13. Emphysema	☐	☐
14. Tuberculosis	☐	☐
15. Asthma	☐	☐
16. Breathing or sleep problems (snoring, sinus)	☐	☐
17. Kidney disease	☐	☐
18 Liver disease	☐	☐
19. Jaundice	☐	☐
20. Thyroid or parathyroid disease	☐	☐
21 Hormone deficiency	☐	☐
22. High cholesterol	☐	☐
23. Diabetes	☐	☐
24. Stomach or duodenal ulcer	☐	☐
25. Digestive disorders (gastric reflux)	☐	☐
26. Osteoporosis/osteopenia, taking bisphosphonates	☐	☐
27. Arthritis	☐	☐
28. Glaucoma	☐	☐
29. Contact lenses	☐	☐
30. Head or neck injuries	☐	☐
31. Epilepsy, convulsions, (seizures)	☐	☐
32. Neurological problems	☐	☐
33. Viral infections and/or cold sores	☐	☐
34. Any lumps or swelling in the mouth	☐	☐
35. Hives, skin rash and/or hay fever	☐	☐
36. Venereal disease	☐	☐
37. Hepatitis (type______)	☐	☐
38. HIV/AIDS	☐	☐
39. Tumor, abnormal growth	☐	☐
40. Radiation therapy	☐	☐
41. Chemotherapy	☐	☐
42. Psychiatric treatment	☐	☐
43. Antidepressant medication	☐	☐
44. Alcohol/drug dependency	☐	☐

ARE YOU:	YES	NO
45. Presently being treated for other illnesses	☐	☐
46. Aware of a change in your general health	☐	☐
47. Taking medications for weigh management	☐	☐
48. Taking dietary supplements	☐	☐
48. Often exhausted or fatigued	☐	☐
50. Subject to frequent headaches	☐	☐
51. A smoker or smoked previously	☐	☐
52. Often unhappy or depressed	☐	☐
53. WOMAN ONLY: Taking birth control	☐	☐
54. WOMAN ONLY: Pregnant	☐	☐
55. WOMAN ONLY: Nursing	☐	☐
56. MEN ONLY: Prostate disorder	☐	☐

57. Medical treatment(s), impending surgery, and/or treatment which may affect your dental treatment:

____

____

____

____

58. All medications, supplements and/or vitamins taken within the last 2-years: (Please, ask for an additional sheet if you are taking more than 4 medications).
Please advise us in the future of any changes in your medical history or of any medications you may be taking.

Medication/supplement/vitamin	Dose	Frequency	Purpose

Patient or Parent/Guardian Signature: ______________________ Date: __________

Doctor Signature: ______________________ Date: __________

DENTAL HISTORY

Referred by: ______________ How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Previous Dentist: ______________ How long have you been a patient? ______________ Months/Years
Date of 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? ☐ 3 months ☐ 4 months ☐ 6 months ☐ 12 months ☐ Not Routinely
What is your immediate concern? ______________

PERSONAL HISTORY

		YES	NO
1.	Are you fearful of dental treatment?	☐	☐
2.	Have you had an unfavorable dental experience?	☐	☐
3.	Have you ever had trouble getting numb or had reactions to local anesthetic?	☐	☐
4.	Did you ever have braces, orthodontic treatment or had your bite adjusted?	☐	☐
5.	Have you ever had teeth removed?	☐	☐

SMILE CHARACTERISTICS

7.	Is there anything about the appearance of your teeth that you would like to change?	☐	☐
8.	Have you ever whitened (bleached) your teeth?	☐	☐
9.	Are you self-conscious about your teeth?	☐	☐
10.	Have you been disappointed with the appearance of previous dental work?	☐	☐

BITE AND JAW JOINT

11.	Do you/would you have any problems chewing gum?	☐	☐
12.	Do you/would you have any problems chewing bagels or other hard foods?	☐	☐
13.	Have your teeth changed in the last 5-years, become shorter, thinner or worn?	☐	☐
14.	Are your teeth crowding or developing spaces?	☐	☐
15.	Do you have more than one bite or do you clench (squeeze) to make your teeth fit together?	☐	☐
16.	Do you have any problems with sleep or wake up with an awareness of your teeth?	☐	☐
17.	Do you have problems with your jaw joint? (Pain, sounds, limited opening, locking and/or popping).	☐	☐
18.	Do you have tension headaches or sore teeth?	☐	☐
19.	Do you wear or have you ever worn a bite appliance?	☐	☐

TOOTH STRUCTURE

20.	Have you had any cavities in the past 3-years?	☐	☐
21.	Do you have dry mouth?	☐	☐
22.	Are your teeth sensitive to hot, cold, biting or sweets?	☐	☐
23.	Have you ever had a toothache, a cracked filling, broken, chipped or cracked tooth?	☐	☐
24.	Do you avoid brushing any part of your mouth?	☐	☐
25.	Do you feel or notice any holes (pitting) in your teeth?	☐	☐

GUM AND BONE

26.	Have you ever been diagnosed or treated for periodontal (gum) disease?	☐	☐
27.	Have you ever experienced gum recession?	☐	☐
28.	Is there anyone with a history of periodontal disease in your family?	☐	☐
29.	Do your gums bleed when brushing, flossing or eating?	☐	☐
30.	Are your teeth becoming loose?	☐	☐
31.	Have you ever noticed an unpleasant taste or odor in your mouth?	☐	☐

Patient or Parent/Guardian Signature: ______________ Date: ______________

Doctor Signature: ______________ Date: ______________

OFFICE POLICIES

READ & INITIAL AFTER REVIEWING OUR OFFICE POLICIES. PLEASE PAY ATTENTION TO POLICIES WHICH HAVE AN * BY THEM.

SCHEDULING POLICY* While we will make every effort to accommodate our patients' busy schedules, our policy is to reschedule any patient arriving 10-minutes or later for their appointment, so as not to inconvenience others for whom we have reserved time. In these situations, we may shorten or reschedule your appointment, depending upon the time we have reserved for others this day.

Patient or Parent/Guardian Initials: ____________________

PEDIATRIC CARE *(For Parent/Guardian completing form for child)* For all patients who are below the legal age of 18, a legal guardian/parent must be present at the time of the appointment as well as, for scheduling of future appointments. All appointments will be made and confirmed through the parent/legal guardian.

Patient or Parent/Guardian Initials: ____________________

CANCELLATION POLICY* We require two working days' notice (48 hours) to reschedule or cancel appointments. For each hour reserved for your appointment, a $65.00 fee will be assessed for late arrivals and/or failure to keep an appointment. Please respect our practice and other patients' time by informing us as soon as possible when you are unable to make an appointment. We try our best to give a reminder call 1 or 2 of OUR busines days prior to your appointment. Please note that these calls are courtesy calls: your appointment is still your responsibility.

Patient or Parent/Guardian Initials: ____________________

ESTIMATION OF DENTAL BENEFITS* I understand that Bellecare Dental can only provide an estimate of dental insurance benefits and cannot guarantee payment by my insurance company. I understand, although my insurance states services are covered there is no guarantee of coverage until claims have been processed through the insurance company. I agree to pay any difference of a claim if the insurance does not cover my services rendered. It is in my best interest to understand my benefits as coverage varies from plan to plan (even within the same company). If I request, Bellecare Dental will submit a predetermination of benefits to my insurance company prior to beginning treatment. If my account should be placed in the hands of an attorney for collections or if suit shall be brought to collect any of the principal, interest or monthly billing fee of this account, I promise to pay reasonable attorney's fee and cost of such suit.

Patient or Parent/Guardian Initials: ____________________

PHOTOGRAPHY I understand that as a part of my care, photographs may be taken of my teeth and face: the publication or showing of these photographs will be for insurance related and healthcare operations only. Photographs of mouth and teeth might be used for promotional purposes.

Patient or Parent/Guardian Initials: ____________________

RELEASE OF BENEFITS AND INFORMATION I authorize my insurance benefits to be paid directly to Bellecare Dental. I am responsible for payment of my account even though an insurance claim has been filed. To the extent permitted under applicable law, I authorize Bellecare Dental to release information relating to the claim. I am responsible for the portion not covered by insurance on the day of my appointment.

Patient or Parent/Guardian Initials: ____________________

Patient or Parent/Guardian Signature: ______________________________ Date: ______________

Staff Member Signature: ______________________________ Date: ______________

FINANCIAL POLICY AGREEMENT

PLEASE REVIEW THE FOLLOWING INFORMATION, SIGN AND DATE BELOW. PLEASE PAY SPECIAL ATTENTION TO POLICIES WHICH HAVE AN * BY THEM. THANK YOU!

OUTSTANDING PATIENT SERVICE IS OUR GOAL: Our goal at Bellecare Dental is to ensure you receive the highest quality dental care and service. An important step towards this goal is to make certain our financial policies are clear and understood by you, our patient.

*INSURANCE: If you have insurance, we will make a good faith estimate of your eligible benefits. Our office will handle the process of completing and filing the appropriate forms with your insurance provider, track your claim(s) to ensure payment is issued in a timely manner, as well as, provide and requested x-rays and/or other information required for your claim.

If a claim is denied, as a courtesy, we will resubmit you claim to your insurance for a second time. If your insurer denies coverage due to incorrect policy holder information provided by you, the patient, to our office, the balance of a claim will become the responsibility of the patient. We will be glad to provide all information when/if an attempt is made to process the denied claim. Please remember, your insurance coverage is a contract between you and your insurer and/or your employer and your insurer. Although we will make every effort to help you obtain your benefits, we cannot require your insurer to pay.

I understand although my insurance states services are covered there is no guarantee of coverage for services until the claim has been processed. I agree to pay any difference of a claim if the insurance denies coverage of services rendered.

Patient or Parent/Guardian Initials: ____________________

PAYMENT DUE AT TIME OF SERVICE: Co-pays for service are due at the time of your treatment after deduction of your good faith estimate of insurance benefits. Prior to your treatment, a *Needed Treatment and Estimated Co-pay* breakdown will be reviewed and signed by you, the patient, in conjunction with a signed Standard *Consent for Dental Treatment* form.

*PAYMENT OPTIONS: We accept cash, check, Visa and MasterCard. For patients seeking an extended deferred payment option, Care Credit (a no interest medical line of credit) is available. If you would like to take advantage of this deferred payment option though Care Credit, please inform the front office. The application process only takes a few minutes. For a balance broken into two or more payments, please consult with our front office about setting up an in-house payment agreement.

Please note, for first appointments, payments must be made via cash, Visa, or MasterCard. Thereafter, checks may be accepted for payment. If a check does not clear, up to a $40 NSF service charge will be posted to your account for each check.

*YOUR RESPONSIBILITY: I acknowledge my responsibility for payment of services received from Bellecare Dental in accordance with their regular fees and terms. I understand my account becomes delinquent if not paid within 30 days after a date of service. At this time a monthly finance charge of 1.8% of the account balance will be posted to my account until the balance is paid in full.

ASSIGNMENT AND RELEASE: I authorize payment to be issued directly to Bellecare Dental c/o Dr. Stacy L. Pacheco by my insurance company. I accept financial responsibility for services not covered by my insurance and authorize release of any health care information requested by my insurance carrier.

Patient or Parent/Guardian Signature: ____ Date: ____________

Staff Member Signature: ____ Date: ____________

GENERAL CONSENT FOR TREATMENT

PLEASE REVIEW THE FOLLOWING INFORMATION IN REGARDS TOWARDS TREATMENT. IT IS IMPORTANT TO UNDERSTAND ALL DENTAL AND ANESTHETIC PROCEDURES HAVE ASSOCIATED RISKS.

THESE MAY BE BUT ARE NOT LIMITED TO:

1. Drug reactions and side effects.
2. Damage to adjacent teeth or fillings.
3. Post-operative infection.
4. Post-operative bleeding which may require additional treatment.
5. Bruising, swelling, sensitivity or pain.
6. Failure of the dental procedure necessitating additional treatment.
7. Complications during treatment necessitating referral to a specialist.

I, the patient, understand I have the right to ask questions about my treatment, including alternatives and risks, as well as, the consequence of doing nothing.

Patient or Parent/Guardian Signature: ______________________ Date: __________

Staff Member Signature: ______________________ Date: __________

HIPPA ACKNOWLEDGEMENT OF PRIVACY PRACTICES

My signature confirms I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in my treatment directly and/or indirectly.
- Obtain payment from third-party payers for my health care services.
- Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my dental provider's *Notice of Privacy Practices* which contains a more complete description of the uses and disclosures of my health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand my dental provider has the right to change the *Notice of Privacy Practices* and I may contact the office at the address noted below to obtain a current copy of the *Notice of Privacy Practices*.

I understand I may request in writing that you restrict how my private information is used or disclosed to carry out treatment and/or payment of health care operations. I understand the practice is not required to agree to my requested restrictions, however, if agreed to then the practice is bound to abide by such restrictions.

Signature: ______________________________ Date: ______________________

Print Name: ______________________________ Relationship to Patient: ______________

Please note dependent family members are also covered by this acknowledgment

-- FOR OFFICE USE --

We were unable to obtain the patient's written acknowledgement of our *Notice of Privacy Practices* due to the following:

☐ Patient refused to sign ☐ Emergency situation

☐ Communication barriers ☐ Other: ______________________

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