PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

Referred By

Previous Dentist

Emergency Contact

Emergency Contact #

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other?	☐	If yes
Do you use controlled substances?	◯ Yes ◯ No	If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Fainting	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No	Frequent Diarrhea	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stomach/Intestinal	◯ Yes ◯ No
Breathing Problems	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Genital Herpes	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Cold Sores/Fever	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No
Congenital Heart	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No
						Yellow Jaundice	◯ Yes ◯ No

Have you ever had any serious illness not listed	◯ Yes ◯ No	If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to

Signature of Patient, Parent or Guardian:

X Date:_____

DENTAL HISTORY

How would you describe your dental health? ☐ Good ☐ Fair ☐ Poor

Why have you come to the dentist today? Are you currently experiencing any pain or discomfort?

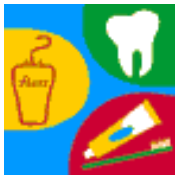
☐ Regular Check Up ☐ Pain …where? _____

How do you feel about your smile and appearance of your teeth? _____

What would you change about your smile? (i.e. Color, position, spacing, length, width, and gumline)

_____

When was your…



Last dental visit ? _____

Last dental Cleaning? _____

Last X-rays taken? _____ *☐Full set* *☐ Limited*

What treatment was performed at your last visit? ☐ Fillings ☐ Bridges ☐ Extraction ☐ Crowns _____

Have you had any major dental treatment in the last 5 years? (Bridgework, gum therapy, orthodontic work) ☐ Y ☐ N

_____

Have your past dental experiences been comfortable and pleasant? ☐ Y ☐ N _____

Is there any dental treatment that makes you anxious? ☐ Y ☐ N _____

How often do you brush daily? ☐1x ☐2x ☐3x _____ When do you brush? ☐AM ☐PM

Type of bristles: ☐soft ☐medium ☐hard

Do you brush your tongue? ☐Y ☐N Do you use dental floss? ☐Y ☐N

Do you use mouthwash or other home care products? ☐Y ☐N_____

Have you ever been instructed on proper home care? ☐Y ☐N

Do you.. ☐ Grind or clench your teeth ☐ Have any loose teeth

☐ Think you have bad breath ☐ Have any spaces where there previously were none

☐ Bleed when you brush or floss ☐ Have any history of trauma to your face/ mouth

☐ Get sores or growths in your mouth ☐ Have pain or clicking in your jaw joint (around your ears)

☐ Have a dry mouth ☐ Have very sensitive teeth

TAILOR-MADE SMILES

455 Union Avenue, Rutherford, NJ 07070
201-933-7550

PRACTICE POLICY

We believe in the importance of quality dental care, and we strive to provide the best dental treatment possible. We look forward to working with you to achieve excellent dental health.

In efforts to keep our costs low and convenient while providing an excellent standard of care, we require our patients to provide total payment at time of service. This payment can be Cash, Check, Visa, MasterCard, Discovery, American Express, or financing options through CareCredit. Any unpaid account balances must be paid immediately unless financial arrangements are made. Any account balances over 30 days from the date of service are subject to 1.5% monthly interest. $5 monthly billing fees will apply. Any balances not paid in a reasonable time will be sent to a collection agency and may be sent to an attorney for litigation. You will be responsible for all associated costs and fees. A copy of photo identification will be taken. There will be a $25 fee for any returned check.

_____ _____

Signature Date

Our office is compliant with HIPAA Laws. We will keep all of your information confidential. You may have a copy of our privacy policy. A copy is provided in the waiting room.

_____ _____

Signature Date

The undersigned hereby authorizes the Doctor or staff to take photographs, radiographs, study models, or any other diagnostic aids deemed appropriate by the Doctor in order to make a thorough diagnosis of the patient's dental needs.

_____ _____

Signature Date

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APPOINTMENT GUIDELINES

We pre-plan and prepare for your visit and hope you have done the same. Your appointment time has been reserved especially for you and we strongly encourage all patients to keep their appointments. When time is lost due to last-minute appointment changes, other patients in need of treatment cannot be seen and your treatment is delayed.

Should any scheduling changes be required, **we require at least 24 hours advance notice to avoid a $50 cancellation fee**.

We consider all appointments confirmed when they are made. As a courtesy, we provide reminders by text message and email prior to the appointment. If text message or emails are not possible, please let us know.

_____ _____

Signature Date

TAILOR-MADE SMILES

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201-933-7550

INSURANCE GUIDELINES

We are glad you have dental insurance to help you with partial assistance in affording your dental care. As a courtesy, we are happy to assist you in filing the necessary forms to help you receive the full benefits of your dental insurance coverage at no additional cost. Dental insurance is different than most medical insurance plans and it is important to be aware of the following:

- **Insurance is an agreement between you and your insurance company**. The insurance relationship constitutes an agreement between the carrier, the employer, and the patient. Our dental office is not a party to that contract. As such, we can make no guarantee of estimated coverage or payment.
- **Full dental fees are not always covered**. Insurance companies base the amounts they pay on the restrictive fee schedules, regardless of what the actual fee may be. Our fees are often, but not necessarily, covered in full by the maximum allowance determined by your carrier.
- **Not all your care may be covered**. Not all dental services that are necessary for proper dental health are a covered benefit in all contracts. This depends on the kind of plan you or your employer has purchased.
- **Deductibles and Co-payments must be collected**. Deductibles and co-payments are built into most plans and their required payment strictly regulated by state law. Your employee Benefits Director can usually help you become familiar with your plan and its restrictions.

Here's What We Promise To Do:

1. Complete insurance claim forms and submit to your carrier.
2. Use current American Dental Association coding for correct reporting of procedures.
3. Accept direct payment from your carrier and keep track of balances.
4. If necessary, re-file your insurance claim a second time within a 30-60 day period.

Your Responsibilities Will Be:

1. To pay fees not covered by your plan at the time of treatment or as otherwise arranged.
2. To provide our office with necessary information concerning your insurance coverage to allow correct filing of claims.
3. To understand that your plan is a contract between you, your employer, and the insurance carrier. Our office will do all we can to facilitate claims payment, but we do not have the power to force your insurance to pay.

Thank you for choosing our office for your dental needs. Please know that we will do everything possible to see that you receive the full benefits of your insurance policy.

I hereby authorize payments of the insurance benefits to be made directly to this dental office. I understand that any insurance coverage estimate given to me by this office is not a guarantee of actual insurance payment. I also understand that I am ultimately responsible for all charges incurred for dentistry performed upon myself or my dependents in this dental office. I authorize release of my dental/medical histories and other information about my dental treatment to third party payers.

_____ _____

Patient or Insured Date

Optional: To provide a credit card on file to clear all balances left after insurance payments are made.

Credit Card Type: ☐ Visa ☐ MasterCard ☐ CareCredit

Credit Card Number: _____

Security Code: _____

Expiration Date: _____

Name on Card: _____

Billing Zip Code: _____

Signature: _____

E-mail Address for receipt:_____