

Patient Registration

Patient Name _____ Birth Date _____ Age _____

SS# _____ DL# _____ Occupation _____

Single Married Divorced Widowed Spouse's Name: _____ Phone# (____) _____

Home Address _____ City _____ State _____ Zip _____

Home # (____) _____ Cell Phone # (____) _____ Work # (____) _____

E- Mail Address _____

Employer Name and Address _____

Person Responsible for Account _____ Relationship _____

Social Security # _____ DL# _____ Home # (____) _____

Home Address (if different) _____ State _____ Zip _____

Employer & Address _____ State _____ Zip _____

Whom may we thank for referring you to our office? _____

What are your concerns? *Mark all that apply:* Routine Checkup cleaning Appearance Pain Avoidance
 Cavities Losing Teeth Oral Cancer Gum/Periodontal Disease Other _____

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Medical/Dental History

1. When was your last dental visit? _____ Reason: _____

When was your last dental cleaning? _____

2. Are you currently under the care of a physician? Yes No If yes, Reason: _____

Physician's Name: _____ Physician's Phone # _____

3. **Are you taking any medications?** Yes No List: _____

4. Are you **allergic** to any of the following: Penicillin/Amoxicillin Latex Sulfur Codeine Novocain Aspirin Other: _____

5. *Has your physician ever informed you that you have or had?*

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Heart Ailment | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Stroke | <input type="checkbox"/> Fainting / Dizziness |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Psychiatric Treatment |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis A B C |
| <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Tumors or Growths | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Stomach / Intestinal Disease | <input type="checkbox"/> Epilepsy / Convulsions | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> HIV+/AIDS |
| <input type="checkbox"/> Thyroid Trouble / Goiter | <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Eczema / Hives | <input type="checkbox"/> Addiction/Drug Abuse |
| <input type="checkbox"/> Anemia / Leukemia / Low Platelets | <input type="checkbox"/> Prostate | <input type="checkbox"/> Cancer Treatment | Are you Pregnant? |
| <input type="checkbox"/> Rheumatism or Arthritis | <input type="checkbox"/> Asthma / Hay Fever | <input type="checkbox"/> Smoke/Chew Tobacco | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Other _____

Organ / Valve / Joint / Replacement and/or Implant: Type: _____

***Have you been told that you need to take antibiotics with dental treatment? Yes No

Please Initial

_____ I acknowledge that I have been given or offered a copy of the offices "Notice of Privacy Practices."

_____ I understand that payment is due at the time of service and that I am fully financially responsible for all charges.

_____ I understand that if my account is sent to collections I will be responsible for a \$65 collection fee and any attorney fees and court cost associated.

Signature: _____

Date: _____

OVER PLEASE ↻

Insurance Information / Release Form

Policy Holder's Information

Policy Holder's Name _____ Male Female _____ / ____ / ____ Birth Date _____ - ____ - ____ Social Security Number

Spouses Name _____ Male Female _____ / ____ / ____ Birth Date _____ - ____ - ____ Social Security Number

Insurance Information

Employer _____ Address _____ City _____ Zip _____ Phone Number _____

Insurance Company _____ Address _____ City _____ Zip _____ Phone Number _____

ID Number _____ Group Number _____ Plan Number _____

Dependent's Name (last name if different than yours)

Dependent _____ Male Female _____ / ____ / ____ Birth Date

Dependent _____ Male Female _____ / ____ / ____ Birth Date

Dependent _____ Male Female _____ / ____ / ____ Birth Date

Secondary Insurance Information

Policy Holder's Name _____ Male Female _____ / ____ / ____ Birthday _____ - ____ - ____ Social Security Number

Employer _____ Address _____ City _____ Zip _____ Phone Number _____

Insurance Company _____ Address _____ City _____ Zip _____ Phone Number _____

ID Number _____ Group Number _____ Plan Number _____

Please Initial: _____ I authorize release of any information relating to my claim.
_____ I authorize payment directly to Dental Depot.
_____ I understand that all fees not paid by insurance are my responsibility.

_____ Print Patient Name _____ Patient or Guardian Signature _____ Date

Failed Appointment & Short Notice Cancellation Policy

Down to Earth Dental takes great pride in providing high quality dental care. When we schedule your appointment we do so in a way that we can spend quality time with you. It is also a priority to us that we see you promptly at your appointment time. We ask the same courtesy of you.

Please be aware of our policy regarding no-shows and last minute cancellations.

When an appointment is cancelled without at least a **24 hour** notice or you fail to arrive for your appointment, you will be charged **\$45 (per hour)** for a missed appointment fee.

*If a two hour appointment is set aside for you, we ask that you give a 48 hour notice.

If two appointments are missed we reserve the right to discontinue seeing you at this office.

I, _____ understand and agree to the following policy.
(Patient or Guardian Printed Name)

X _____
Signed (Patient or Guardian)

Date