PATIENT REGISTRATION

Name: ____ SSN #: _________-________-__________

Address: ____

City: __________________ State: ________ Zip: _____________ Phone: _(______) _______-_________

Cell: _(______) _______-_________ Email: ____

DOB: ______/______/________ Sex: F M Single Married Divorce Child

Patient Employed By: ____________________________________ Occupation: ________________________

Business Address: ____

City: __________________ State: ________ Zip: _____________ Phone: _(______) _______-_________

Emergency Contact: ______________________________________ Phone: _(______) _______-_________

Whom may we thank for referring you? ____

DENTAL HISTORY

What would you like us to do today? ____

Date of Last Dental Care: ______/______/________ Date of Last X-Rays: ______/______/________

PLEASE CIRCLE IF YOU HAVE HAD ANY OF THE FOLLOWING:

Bad Breath | Bleeding Gums | Clicking or Popping Jaw | Food collection in between teeth

Hot sensitivity | Cold sensitivity | Sweet sensitivity | Biting sensitivity

Grinding/Clinching | Sores or growths in mouth | Previous Periodontal Treatment

Have often do you brush? ________________________________ Floss? ________________________________

How do you feel about the appearance of your teeth? ____

DENTAL INSURANCE

Insured Person: ____________________________________ Relation to Patient: ________________________

Date of Birth: ______/______/________ SSN #: _________-________-__________

Address (if different from above): ____

City: __________________ State: ________ Zip: _____________ Phone: _(______) _______-_________

Cell: _(______) _______-_________ Email: ____

Employed By: ____________________________________ Occupation: ________________________________

Insurance Co: ____ Phone: _(______) _______-_________

Ins Co Address: ___________________________ City: _________________ State: ________ Zip: ____________

Subscriber ID#: ______________________________________ Group #: _______________________________

MEDICAL HISTORY

Name: ____ DOB: ______/______/________

Date of last medical exam: ______/______/________

Have you had any serious illnesses or operations? YES NO If YES please describe: ______________

____

Are you currently under a physicians care? YES NO If YES, please describe: ____________________

____

PLEASE CIRCLE IF YOU CURRENTLY HAVE ANY OF THE FOLLOWING:

Artificial Heart Valves	AIDS/HIV Positive	Psychiatric Care	Dental Phobic
Aspirin ________mg	Hepatitis: A B C	Thyroid Disease	Hemophilia
Diabetes: Type 1 Type 2	High Blood Pressure	Hard of Hearing	Dementia
Mitral Valve Prolapse w/Regurgitation	Seizures or Fainting	Kidney Disease	Pregnant
Previous Infectious Endocarditis	Cardiac Transplant	Blood Thinners	Asthma
Congenital Heart Disease	High Cholesterol	Tobacco Habit	MRSA
Other: _______________________	Liver Disease	Pace Maker	Stroke

Artificial Joints: ________ Date: ________________ Bone Replacement Meds Date: _________________

Have your ever had an adverse reaction to a medical or dental procedure? NO YES

If yes, please explain: ____

Is the patient currently taking any medications (INCLUDING OVER THE COUNTER & HEALTH FOOD SUPPLEMENTS?) Please list: ____

____

Does the patient have any drug allergies? YES NO If YES, please describe: _____________________

____

AUTHORIZATION

I understand the notice of practices and give my permission to Elegant Dentistry to mail my unsealed postcard to remind me of my appointment.

I consent to treatment, as necessary, to care for the patient named above. I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge and is only for use in my treatment, billing or processing of insurance benefits. I authorize the insurance company to pay the dentist all insurance benefits otherwise payable to me.

I authorize the dentist to release all information necessary to secure payment of benefits. I understand that I am financially responsible for all charges whether paid or not by insurance. All patients are required to take full mouth series x-rays or FMX, at their first complete exam appointment and every 3 to 5 years; depending their oral and medical health. Bitewing x-rays are required minimum once a year.

Signature: ____ Date: ______/______/________

PAYMENT IN FULL IS DUE AT THE TIME OF TREATMENT

13925 West Meeker Boulevard, Suite 1A · Sun City West, AZ 85375 · Phone: (623)584- 0733 · Fax: (623) 584-1799

INSURANCE POLICY

We believe that you deserve the best care. That's why we always present you with the best dental solutions possible to treat your personal situation. Each year we provide outstanding dental care to hundreds of patients. Some have dental insurance but some don't. If you have dental benefits, congratulations! You are very fortunate. Here are some important things you should know:

Please Initial:

- _______ Your dental benefits are based upon a contract made between you (former) employer and an insurance company. **If you have questions regarding you dental benefits please contact your employer or insurance company directly. Dental benefits will not pay 100% of you dental care. It is meant to assist you.**
- _______ We currently accept all private care insurance plans (plans that don't require you to select a dentist from a list) and several PPO's (plans that we are contracted with) This means we work with literally thousands of companies. Although we maintain computerized histories of payment by a given company, they do change; therefore it is impossible to give you a guaranteed quote at the time of service. We estimate our portion based on the most up-to date information we have, but it is **ONLY AN ESTIMATE.** If you would like, we can file a "pre-treatment authorization" with your insurance company prior to that start of treatment. Keep in mind this is not a guarantee of coverage. It does delay treatment but will give you the estimated out-of-pocket figures you are looking for.
- _______ **We bill your insurance as a courtesy.** If insurance does not pay within 90 days, we reserve the right to request payment in full for services from you and let you collect the insurance funds that are due to you. This is rare but it is important that you recognize that the insurance you have is a legal contract between YOU and your insurance company. Our office is not and cannot be a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.
- _______ Our office does require payment in full for your portion **AT THE FIRST SCHEDULED APPOINTMENT.** We accept Cash, Check, Visa, MasterCard, Discover and Debt card. If you are in need of an extended financing option, we also work with Care Credit, who offers 6 or 12 months "same as cash" or longer terms with interest on approved credit.
- _______ A specific amount of time is reserved for you and we strongly encourage all patients to keep their appointments. If you must change you appointment, we require at least **24 hours** notice to avoid a **$50/hour cancellation fee.** (emergencies are an exception)

PRIVACY AGREEMENT

I understand the Notice of Privacy Practices and give permission to Elegant Dentistry to mail my unsealed postcard to remind me of my appointment. This office has the most modern equipment, uses the latest up to date techniques and follows OSHA guidelines in sterilization technology for both staff and patient protection.

I agree with the above conditions.

Signature: ____ Date: ______/______/________

Patient Name (please print): ____

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