PATIENT REGISTRATION

Date: _____

Patient Information

Patient's Name_____ Date of Birth_____

Patient's Social Security #_____ Parent's Name (minors)_____

Street Address_____

Home Phone #_____ Cell Phone #_____

Email_____

In case of emergency, whom should be notified?

Name_____Relationship_____ Phone #_____

How did you hear about our office? _____

Employer_____ Employer Phone #_____

Employer Addresss_____

Insurance Information

Insurance Company_____ Policy No.#_____

Policy Holder Name_____ Relationship_____ Date of Birth_____

Social Security #_____

Employer_____ Employer Phone #_____

Employer Addresss_____

DENTAL HISTORY

What is the reason for your visit?_____

Date of Last Dental Visit_____Date of last x-rays_____

Do you have bleeding/swollen gums ☐yes ☐no

Do you have sensitivity to hot/cold ☐yes ☐no

Do you use: Dental Floss ☐yes ☐no Electric Toothbrush ☐yes ☐no

Do you clench or grind your teeth? ☐yes ☐no Do you snore? ☐yes ☐no

Do you like the way your teeth look? ☐yes ☐no

Is there anything else you would like us to know about your past dental treatment?

_____

(turn over)

HEALTH HISTORY

Physician's Name_____ Date of last physical_____

Are you under medical care at this time? ☐yes ☐no

If yes, please explain_____

Please list current medications_____

Have you ever be prescribed bisphosphonates (i.e. boniva)_____

Please list allergies (i.e. penicillin, local anesthetic, latex)_____

Do/did you use tobacco products ☐yes ☐no

Please check what applies to you:

Heart problems (i.e.angina)	☐yes ☐no	Liver disease/Hepatitis	☐yes ☐no
Heart attack/stroke	☐yes ☐no	Diabetes	☐yes ☐no
Pacemaker	☐yes ☐no	Stomach/GI problems	☐yes ☐no
Artificial heart valves	☐yes ☐no	Kidney Problems	☐yes ☐no
High/low blood pressure	☐yes ☐no	Psychiatric disorders	☐yes ☐no
Heart murmur	☐yes ☐no	Fainting/Seizures	☐yes ☐no
Rheumatic fever	☐yes ☐no	HIV/AIDS	☐yes ☐no
Asthma/lung disease	☐yes ☐no	Abnormal bleeding	☐yes ☐no
Joint replacement	☐yes ☐no	Anemia/blood disorder	☐yes ☐no
Thyroid problems	☐yes ☐no	Cancer	☐yes ☐no
Sexually transmitted infection	☐yes ☐no	Major operations	☐yes ☐no
Pregnancy/lactating	☐yes ☐no		

If you have any other medical conditions or if you answered "yes" to any of the above, please explain_____

_____

_____

_____

Patient/Guardian Signature Date

FINANCIAL POLICY

Thank you for choosing Madison Dental Arts as your primary dental care provider. We are committed to delivering the highest quality of dental care, so that you may attain optimum oral health. Please understand that your financial obligation is considered a part of your treatment.

As a courtesy to you, we will help by processing all of your dental insurance claims. We expect you to supply our office with any insurance information at the date of service. Please understand that we will have an insurance estimate provided to you, however it is not a guarantee that your insurance will pay exactly as estimated. Please be aware that some, and perhaps all of the services rendered may not be covered under your individual insurance policy. It is also your responsibility to request a pretreatment authorization if you would like one prior to the rendering of your treatment. We must emphasize that as your dental provider, our relationship is with you--our patient--and not with your insurance company. We recommended necessary treatment to our patients based on our patients' best interest, and not what the insurance companies will contribute.

We require that you either pay your portion of the bill at the time of service, or that a suitable written financial agreement be reached at the time of service.

If an appointment has been reserved for you, we kindly ask that patients give us twenty-four hours' notice for cancellations; otherwise, we reserve the right to charge a cancellation fee.

We hope to foster a long-term relationship with our patients, and look forward to taking care of you!

_____

Patient/Guardian Signature Date