



Patient Registration Form

Thank you for selecting our dental health team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask us. We will be happy to help.

Patient Information:

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____ Date of Birth: ___/___/___ SS#: _____ - _____ - _____

Marital Status (Circle One): S M D W Gender (Circle One): M F

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

Spouse's Name: _____ Date of Birth: _____

Person Responsible for the Account (If someone other than the patient): _____

SS#: _____ - _____ - _____ Date of Birth: ___/___/___ Relationship to patient _____

Employer Name and Address: _____

How did you hear about us? Internet _____ Phone Book _____ Newspaper _____ Hospital _____

 Patient _____ Other _____

Primary Dental Insurance Information:

Name of Insured: _____ Relationship: _____

Subscriber's Date of Birth: ___/___/___ Subscriber's SS#: _____ - _____ - _____

Dental Insurance Company: _____ Insurance Phone: (____) _____

Subscriber Number: _____ Group Number: _____

Employer Name: _____

Secondary Dental Coverage:

Do you have secondary dental insurance coverage? (Circle one) Yes No

If yes, please provide information on your coverage. We will be happy to file your secondary claim for you. However, you are responsible for all co-payments before your secondary insurance is filed. Your secondary insurance will be instructed to reimburse you directly.

Name of Insured: _____ Relationship: _____

Subscriber's Date of Birth ___/___/___ Subscriber's SS#: _____ - _____ - _____

Dental Insurance Company: _____ Insurance Phone: (____) _____

Subscriber Number: _____ Group Number: _____

Employer Name: _____

Insurance Co. Phone (____) _____

Children under 16 must be accompanied by an adult (guardian). 16 to 18-year olds must have guardian's written consent for treatment.

I acknowledge that I am responsible for all insurance copayments on the day of service including services performed that are not covered by my insurance provider. As a courtesy, Canon Family Dental will submit dental insurance claims and accepts no responsibility for the amount, length, or scope of my provider's coverage. Should situations arise concerning my dental coverage, I understand it is my responsibility to contact my insurance provider. In addition, I understand I am required to pay in full for all treatment performed at the time of service even if Canon Family Dental is not a preferred provider for my dental insurance. In this case, I understand that I will be directly reimbursed by my insurance provider. Insurance coverage estimates provided to me by Canon Family Dental are based on amounts reported by my insurance provider at the time coverage information was requested and are subject to change. Financial Responsibility: In the event that this bill is not paid in full and is subsequently assigned for collections, the consumer or entity signing below hereby agrees to pay collection costs for collection of accounts of \$50 and is responsible for reasonable attorney fees. On all unpaid balances, interest will accrue at 1.5% per month. My signature below indicates I understand and agree to all the above.

Signature: _____

Date: _____



Patient Name: _____

Date: _____

Patient Medical and Dental History

Although dental personnel primarily treat dental conditions, your mouth is part of your entire body. Health problems you may have or medications you may be taking could have an effect on the dentistry you will receive.

Dental History:

Primary reason for this dental appointment: Exam Emergency Consultation

Do you have a specific dental problem? Please explain: _____

Do you think you have active decay or gum disease? Yes No

Do your gums ever bleed? Yes No

Do you like your smile? Yes No

Do you want to keep your remaining teeth? Yes No

Do you have clicking, popping, or discomfort in the jaw joints? Yes No

Preferred Dentist: _____ Preferred Hygienist: _____

Medical History:

Are you under the care of a physician? Yes No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____

Are you taking any medications, pills, or drugs? Please list: _____

Have you received treatment for osteoporosis? Yes No If yes, please explain: _____

Do you use tobacco? Yes No If yes, (circle one): Smoke Chew

Are you allergic to any of the following?

Penicillin Codeine Acrylic Metal Latex Local anesthetics

Other: (Please be specific) _____

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

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Angina | <input type="checkbox"/> Anemia | <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Chemotherapy |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Radiation Treatments |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Asthma | <input type="checkbox"/> Swelling of the Limbs | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Easily Winded | <input type="checkbox"/> Cortisone Medication | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Hepatitis A, B, or C |
| <input type="checkbox"/> Pace Maker | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Drug Addiction |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Gastric Reflux Disease | <input type="checkbox"/> AIDS/HIV |
| <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Stroke | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Autism |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Down Syndrome |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Special Needs (please specify): |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Renal Dialysis | |
| <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Cancer | |

Have you had any other serious illness not listed above? Yes No If yes, please list: _____

Emergency Contact: _____ Phone Number: (____) _____

Physician Name: _____ Phone Number: (____) _____

Women:

Are you: Pregnant Nursing Taking oral contraceptives?

To the best of my knowledge, I have accurately answered the questions on this form. I understand providing incorrect or incomplete information can be dangerous to my (or the patient's) health. It is my responsibility to inform Canon Family Dental of any changes in medical status in a timely manner.

Signature: _____

Date: _____



Financial Guidelines

Please initial each statement below

_____ **Payment is due at time of service**- Individuals with insurance will be required to pay their **estimated** financial responsibility at time of services. For minors of divorced/separated parents the accompanying parent is responsible for the payment at time of service. Canon Family Dental will submit on behalf of the patient, to the insurance, all charges for that day; any remaining balance after the return of the claim will be the patient responsibility and due within 10 days of the statement receipt.

_____ **Finance charges**- Any balances that are carried over 30 days are subject to a finance charge of 18%, accrued monthly. Remaining balances over 90 days are subject to being sent to a collection agency.

_____ **Cost Estimation**- Canon Family Dental will make every effort to provide our patients with upfront cost **estimates**. We will provide every patient with an **estimate** of their out-of-pocket expense before starting a procedure. This will be reviewed and signed by the patient or/and Legal Guardian.

_____ **Pre-Authorizations**- To provide the patient with the most accurate **estimate**, Canon Family Dental will submit on the behalf of the patient, to their insurance, a pre-authorization for procedures \$300.00 and over. Pre-authorizations are not a guarantee of payment from the insurance.

_____ **Down payment**- Procedures \$500.00 and over, such as Dentures, Crowns, Implant Supported Crowns, and Scaling and Root Planning that exceed \$500.00 in patient responsibility, we will require 25% of your **estimated** financial responsibility down to schedule. An additional payment of 25% or more will be due at the start appointment. The remaining balance will be required before or at the time of delivery or final appointment; this will be collected prior to the patient being called back.

By signing below, you acknowledge that you have read the above terms.

Signature of patient or legal guardian

Date

Printed name of Patient or legal guardian



Privacy Practices Acknowledgement/HIPAA

You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. On the laminated sheet attached to the clipboard, we have provided a description of our policies regarding the limited disclosure we may make of your protected health information and of other important matters about your protected health information. We encourage you to read it carefully before signing this consent.

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. This includes, but is not limited to, submission of insurance claims and consultation with dental specialists (endodontists, oral surgeons, periodontists, etc.) if necessary.

I acknowledge that I have had full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that, by signing this form, I am giving my consent to Canon Family Dental to the use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Patient Name: _____ Birth Date: _____

Signature: _____ Date: _____

Missed or Failed Appointment Policy

Canon Family Dental takes great pride in offering quality, comprehensive care for every patient. We are careful in scheduling each appointment so that each patient receives their recommended treatment in a reasonable amount of time while still accommodating individual needs. In order to consistently provide this type of care, it is important for our patients to be on time for their scheduled appointments so we can keep our schedule running smoothly.

Based upon this practice philosophy, Canon Family Dental has adopted a policy regarding no-show or last-minute cancellations. Once you have missed two appointments, you will only be allowed to make a same-day- appointment. A same-day-appointment will require you to call our office on the day you are available, and we will fit you in if there is availability.

Canon Family Dental understands the busy lives of our families and offer family appointments to better accommodate your needs. However, if a family appointment is missed, we will only be able to accommodate you on an individual basis in the future.

If you move or change phone numbers without informing our office, we may be unable to contact you in order to confirm an appointment. In such an instance, your appointment time will not be held for you.

I acknowledge that I have had full opportunity to read the “Missed or Failed Appointment Policy”.

Name: _____ Date: _____