Dental Registration and History

16370 US Hwy 17
Hampstead, NC 28443

HampsteadDentalNC.com
910-270-3602

PATIENT INFORMATION

Date _____

Patient _____
Last Name

_____
First Name Middle Initial

SS# _____

Address _____

City _____

State _____ Zip _____

Email _____

Sex ☐ M ☐ F Age _____

Birth Date _____

☐ Single ☐ Married ☐ Minor

Employed by _____

Occupation _____

Employer Address _____

_____

Employer Phone (_____) _____

Spouse's Name _____

Birth Date _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

DENTAL INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birth Date _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Hampstead Dental all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such submission to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

PHONE NUMBERS

Home (_____) _____ Work (_____) _____ Cell (_____) _____

Spouse's Work (_____) _____ Best time and place to reach you _____

IN AN EMERGENCY, PLEASE NOTIFY:

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

PLEASE COMPLETE REVERSE SIDE

HEALTH HISTORY

Physician's Name _____ Date of last physical _____

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

	Yes	No		Yes	No
High Blood Pressure	☐	☐	Arthritis, Rheumatism	☐	☐
Low Blood Pressure	☐	☐	Joint Replacement	☐	☐
Heart Attack	☐	☐	Back or Neck Injury	☐	☐
Heart Murmur	☐	☐	Blood Disorder or Anemia	☐	☐
Heart Surgery	☐	☐	Abnormal Bleeding with extractions or surgery	☐	☐
Rheumatic Fever	☐	☐			
Stroke	☐	☐	AIDS/HIV	☐	☐
Pacemaker	☐	☐	Syphilis or Gonorrhea	☐	☐
Mitral Valve Prolapse	☐	☐	Herpes	☐	☐
Artificial Heart Valves	☐	☐	I.V. Drug User	☐	☐
Psychotherapy	☐	☐	Chemical Dependency	☐	☐
Epilepsy	☐	☐	Head or Jaw Injury	☐	☐
Fainting or Dizziness	☐	☐	Jaw Pain	☐	☐
Respiratory/Lung Disease	☐	☐	Headaches	☐	☐
Tuberculosis	☐	☐	Glaucoma	☐	☐
Asthma or Emphysema	☐	☐	Dry Mouth	☐	☐
Chronic Cough	☐	☐	Cancer	☐	☐
Kidney Disease	☐	☐	Chemotherapy	☐	☐
Swollen Ankles/Feet	☐	☐	Radiation Treatment	☐	☐
Liver Disease	☐	☐	Organ Transplant	☐	☐
Jaundice	☐	☐	Cortisone Treatment	☐	☐
Hepatitis	☐	☐	Unexplained Weight Loss	☐	☐
Diabetes	☐	☐	Ulcers	☐	☐

Are you under the care of a physician? ☐ Yes ☐ No
If yes, for what? _____

Have you had any serious illness or operation? ☐ Yes ☐ No
If yes, please explain _____

Have you been hospitalized within the past two (2) years? ☐ Yes ☐ No

Have you ever taken any of the groups of drugs collectively referred to as "fen-phen?" ☐ Yes ☐ No

Do you have any reason to suspect you are not in good health? ☐ Yes ☐ No

Do you require **antibiotic premedication** before dental procedures? ☐ Yes ☐ No

Are you **allergic** to or have you had any reactions to any of the following?

Aspirin	☐	Metals	☐
Barbiturates, sleeping pills	☐	Penicillin	☐
Codeine or other narcotics	☐	Sulfa drugs	☐
Iodine	☐	Other(s) _____	
Latex	☐	_____	
Local Anesthetic	☐	No known allergies	☐

Women:

Are you pregnant? ☐ Yes ☐ No Due date _____
Taking birth control pills? ☐ Yes ☐ No
Are you nursing? ☐ Yes ☐ No

Are you taking any medications at this time? ☐ Yes ☐ No
If yes, please list all medications, including all non-prescription

_____
_____
_____
_____
_____
_____

Is there anything else of importance in your medical history that has not been asked? ☐ Yes ☐ No
If yes, please explain _____

DENTAL HISTORY

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

	Yes	No		Yes	No
Bleeding gums	☐	☐	Grind or Clench your teeth	☐	☐
Do you smoke	☐	☐	Chronic facial pain	☐	☐
Do you chew tobacco	☐	☐	Orthodontic treatment	☐	☐
Periodontal (gum) treatment	☐	☐	Sensitivity to Hot or Cold	☐	☐
Swollen or tender gums	☐	☐	Dry mouth	☐	☐
Difficulty in Opening or Closing your jaw	☐	☐	Snoring and/or diagnosed with Sleep Apnea	☐	☐

Reason for today's visit _____
_____
Date of last dental visit _____
How often do you floss? _____
How often do you brush? _____
What improvements would you like to see with your smile?
_____

I certify that I have read and understand the above information. To the best of my knowledge, all of the preceding answers are true and correct. I understand that providing incorrect information can be dangerous to my health.

Patient/Parent/Guardian Signature _____ Date _____

Thank you for taking the time to complete this form!

Consent for Services and Financial Policy

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

☐ ***By checking this box, I understand the above information and agree with its contents. This will serve as my electronic signature for the Administration Form.**

Signature _____ **Date** _____