Patient Registration

Patient Name _____ Birth Date _____ Age_____
First Middle Last
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_____

==========

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?*

❑ Heart Ailment	❑ Rheumatic Fever	❑ Stroke	❑ Fainting / Dizziness
❑ Mitral Valve Prolapse	❑ Blood Disease	❑ Liver Disease	❑ Psychiatric Treatment
❑ High Blood Pressure	❑ Kidney Disease	❑ Diabetes	❑ Hepatitis A B C
❑ Respiratory Disease	❑ Tumors or Growths	❑ Glaucoma	❑ Venereal Disease
❑ Stomach / Intestinal Disease	❑ Epilepsy / Convulsions	❑ Tuberculosis	❑ HIV+/AIDS
❑ Thyroid Trouble / Goiter	❑ Abnormal Bleeding	❑ Eczema / Hives	❑ Addiction/Drug Abuse
❑ Anemia / Leukemia / Low Platelets	❑ Prostate	❑ Cancer Treatment	Are you Pregnant?
❑ Rheumatism or Arthritis	❑ Asthma / Hay Fever	❑ Smoke/Chew Tobacco	❑Yes ❑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

❑ Male
❑ Female

Policy Holder's Name _____ Birth Date ___/___/___ Social Security Number ___-___-___

❑ Male
❑ Female

Spouses Name _____ 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)

❑ Male
❑ Female

Dependent _____ Birth Date ___/___/___

❑ Male
❑ Female

Dependent _____ Birth Date ___/___/___

❑ Male
❑ Female

Dependent _____ Birth Date ___/___/___

Secondary Insurance Information

❑ Male
❑ Female

Policy Holder's Name _____ 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 Down to Earth Dental.

_____ 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