DENTAL REGISTRATION & HISTORY

1 Patient Information

Patient Name: _____
Last First MI

Gender: ☐ Male ☐ Female Birth Date: ____/____/____

SS#: _____

Address: _____

City: _____ State: _____ Zip: _____

E-mail: _____

Phone: (Home) _____ (Cell) _____

☐ Single ☐ Married ☐ Separated ☐ Widowed

☐ Minor ☐ Divorced ☐ Partnered for _____ years

Parent/Guardian: _____

Employer/Occupation: _____

Employer Address: _____

Employer Phone: _____

Spouse's Name: _____

SS# _____ Birth Date: ____/____/____

Spouse's Employer: _____

Who may we thank for referring you? _____

In event of an emergency, whom should we contact? _____

Relation: _____ Phone: (____) _____

Who is your medical doctor? _____

Doctor's Phone: (____) _____

2 Primary Insurance Information

Name of Insured: _____
Last First MI

Insured's Birth Date: ____/____/____

ID #: _____

Group #: _____

Insured's Address: _____

City: _____ State: _____ Zip: _____

Insured's Employer Name: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Plan Name: _____

Insurance Address: _____

City: _____ State: _____ Zip: _____

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practicioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for the remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

_____ _____
Signature Date

3 Office Financial Policy

PAYMENT IS DUE at the time services are rendered. For your convenience we accept cash, Visa, MasterCard, Discover, American Express, personal checks, money orders or registered checks.

INSURANCE benefits are determined by your employer and not your dentist. ANY DEDUCTIBLE OR ESTIMATED CO-PAYMENT AMOUNT WILL BE DUE AT THE TIME OF TREATMENT. Insurance is not a guarantee of payment, they will not pay for all of your costs. Your insurance policy is a contract between you and your insurance company. Your insurance and payment is still your responsibility. As a courtesy we will be glad to file your claim for you if you bring 1) your dental insurance wallet card and 2) all required employer information. You will be expected to pay for services rendered if this office is unable to verify your insurance information before treatment. (IF PAYMENT FOR SERVICES ALREADY RENDERED HAS NOT BEEN PAID IN FULL WITHIN 45 DAYS, EITHER BY YOU OR YOUR INSURANCE COMPANY, THE REMAINING BALANCE FOR TREATMENT IS CONSIDERED DUE AND COLLECTIBILE FROM YOU.)

We reserve the right to charge, and collect fees for Broken Appointments: Appointments that are cancelled or broken without 48 hours advance notice. Appointments are reserved exclusively for you. As a health benefit to you, we may offer to move your appointment to an earlier time if openings arise.

A SERVICE CHARGE of 1% per month (18% per annum) on the UNPAID BALANCE will be charged on all accounts exceeding 90 days, unless previously written financial agreements are satisfied.

RETURNED CHECK FEE of $25.00 will be added to your account balance and is collectible.

PAYMENT PLANS AND FINANCIAL AGREEMENTS can be entered into for comprehensive dental treatment, prior to commencing treatment.

I HAVE READ AND UNDERSTAND THIS FINANCIAL POLICY.

Signature of patient, parent, or guardian (responsible party): _____ Date: _____

Relationship to Patient: _____ Response Date: _____

4 Informed Consent For General Dental Treatment Procedures

I understand that I have the right to authorize or to reject dental treatment that may be recommended by my dentist. I should not consent to dental treatment until I have discussed my expectations for results with my dentist and we have agreed that the results I hope to achieve are reasonable and comply with appropriate clinical standards.

My dentist has shared with me the potential benefits, risks and alternatives of my various treatment options and I need to carefully consider the expected benefits, risks and treatment options, including the option of no treatment.

I have a right to ask questions and to share my concerns with my dentist who will answer my questions and address my concerns. Our goal is to decide on a treatment plan that is mutually acceptable. Once I have authorized a treatment plan, I agree to comply with the phases and timing of treatment necessary to give me the best possible results. Failure to comply with the treatment plan may terminate the doctor/patient relationship.

I understand that no dentist can guarantee the success of a recommended treatment, or that I will not experience a complication, or obtain less than an optimal result. Although many complications are rare, they do occur.

This form is intended to provide me with an understanding there could be potential risks and complications associated with my dental treatment plan. I understand that I should not sign this form or agree to treatment unless I have read, understand, and agreed with each paragraph in this document. My signature below confirms that my dentist and I have discussed the potential benefits, risks, and complications of the recommended treatment and that all of my questions have been answered and my concerns addressed to my satisfaction and that I have elected to proceed with my treatment plan. I also understand that my mouth and teeth are biological systems that are currently changing, and my treatment plan may vary from the original.

Signature of patient, parent, or guardian (responsible party): _____ Date: _____

Relationship to patient: _____ Response Date: _____

Permission To Take Photographs, Slides & Videos

I do hereby authorize Cynthia B. Couch, DMD to take photographs, slides and/or videos of my face, jaws and the hard and soft tissues of my mouth.

I understand that these photographs, slides and/or videos will be a part of my permanent dental records.

I also understand that these photographs, slides and/or videos may be used for educational purposes in lectures, demonstrations, and professional publications and I hereby authorize said use.

Signature of patient, parent, or guardian (responsible party): _____ Date: _____

Relationship to patient: _____ Response Date: _____

I give permission for the doctor and employees of Dr. Cynthia B. Couch to...
(Check the boxes you agree to)

- ☐ Call my home and leave messages on my answering machine regarding appointments.
- ☐ Call my home and leave messages on my answering machine regarding medical information.
- ☐ Call my home and leave messages on my answering machine about insurance/billing issues.
- ☐ Call my place of employment and leave messages for appointment reminders or to return our call.
- ☐ Send postcards regarding my appointment information and hygiene recare due dates.
- ☐ Send medical information, appointment information or other information by mail.

I understand and agree to the above checked statements.

I have received a copy of the NOTICES OF PRIVACY PRACTICES, and have been provided an opportunity to review it.

Signature of patient, parent, or guardian (responsible party): _____ Date: _____

Relationship to patient: _____ Response Date: _____

5 Medical History

Do you have or have you had any of the following diseases, medical conditions or procedures?

- ☐ Heart Attack
- ☐ Pacemaker
- ☐ Mitral Valve Prolapse
- ☐ Congenital Heart Defect
- ☐ Bleeding Problems
- ☐ Nervous Disorder
- ☐ Liver Problems
- ☐ Stomach Problems / Ulcers
- ☐ Alcohol / Drug Abuse
- ☐ Cancer / Tumors
- ☐ HIV+ / AIDS / ARC
- ☐ Emphysema
- ☐ Frequent Neck Pain
- ☐ Xray or Cobalt Treatment
- ☐ Asthma
- ☐ Leukemia
- ☐ Cleft Lip / Palate
- ☐ Stroke
- ☐ Heart Murmur
- ☐ Artificial Valves
- ☐ Chest Pains
- ☐ Scarlet Fever
- ☐ Thyroid Problems
- ☐ Respiratory Problems
- ☐ Mental Disorders
- ☐ Tuberculosis TB
- ☐ Shingles
- ☐ Arthritis / Rheumatism
- ☐ Fainting / Seizures / Epilepsy
- ☐ Back Problems
- ☐ Radiation Treatment
- ☐ Difficulty Breathing
- ☐ Glaucoma
- ☐ Contacts / Glasses
- ☐ Heart Surgery
- ☐ Rheumatic Fever
- ☐ Heart Disease
- ☐ High / Low Blood Pressure
- ☐ Anemia
- ☐ Kidney Problems
- ☐ Sinus Problems
- ☐ Venereal Disease
- ☐ Jaw Problems TMJ / TMD
- ☐ Hepatitis
- ☐ Artificial Bones / Joints
- ☐ Severe / Frequent Headaches
- ☐ Cosmetic Surgery
- ☐ Chemotherapy
- ☐ Diabetes / Hypoglycemia
- ☐ Birth Defects
- ☐ Other

Are you allergic to or ever had a reaction to any of the following?

- ☐ Latex
- ☐ Penicillin / Amoxicillin
- ☐ Codeine
- ☐ Sulfa
- ☐ Aspirin
- ☐ Dental Anesthetics
- ☐ Foods: _____
- ☐ Others: _____

What medications are you currently taking?

- ☐ Pain Killers (including aspirin): _____
- ☐ Muscle Relaxers: _____
- ☐ Blood Thinners: _____
- ☐ Insulin: _____
- ☐ Others, please list: _____

Do you use tobacco in any form?

☐ Yes ☐ No

How much per day? How long?

_____

Have you ever been hospitalized within the past 5 years due to a specific condition?

☐ Yes ☐ No

FOR WOMEN:

Are you taking birth control pills?

☐ Yes ☐ No

Are you pregnant?

☐ Yes ☐ No

If so, how far along are you?

_____

Are you nursing?

☐ Yes ☐ No

Family Physician: _____ **Phone:** (____) _____

Pharmacy Name: _____ **Phone:** (____) _____

6 Dental History

Reason for today's visit:

☐ Exam ☐ Emergency ☐ Consultation

Are you in pain?

☐ Yes ☐ No

Please indicate any of the following problems:

☐ Discomfort, Clicking Or Popping Of The Jaw
☐ Red, Swollen Or Bleeding Gums
☐ Sensitive Tooth, Teeth Or Gums
☐ Blister / Sores In Or Around The Mouth
☐ Lost / Broken Filling(s)
☐ Teeth Grinding
☐ Ringing In Ears
☐ Broken / Chipped Tooth
☐ Stained Teeth
☐ Locking Jaw
☐ Bad Breath
☐ Had A Complication Following Dental Treatment
☐ Other: _____

Do you require pre-medication?

☐ Yes ☐ No ☐ Don't Know

Previous Dentist's Name: _____ **Phone: ( )** _____

Address: _____

Last Dental Exam: ____/____/____ **Last Dental X-rays:** ____/____/____

Times a day you brush? _____ **Times a week you floss?** _____

What type of toothbrush bristles do you use? _____

How would you rate your smile? **1** (worst) **2** **3** **4** **5** **6** **7** **8** **9** **10** (best)

Is there anything you would like to change about your teeth?

☐ Yes ☐ No

If so, what would you change?

☐ Color
☐ Shape
☐ Alignment
☐ Other: _____

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature of patient, parent, or guardian (responsible party): _____ Date: _____

Relationship to patient: _____ Response Date: _____