PATIENT REGISTRATION

Welcome to our practice and thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us. We look forward to meeting you.

Patient First Name: ______________ Last Name: ______________ Middle Initial: ____

Patient is: ☐ Benefit Policy Holder ☐ Responsible Party Preferred Name: ______________

PATIENT INFORMATION

Address: ______________ City: __________ State: ____ Zip: ______

Home phone: __________ Cell: __________ Work: __________ Ext: ______

Birth Date: ___/___/_____ Age: _____ SS #: _____-_____-_____ Driver's License #: __________ State: _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Partnered ☐ Separated ☐ Widowed ☐ Minor

Email: ______________ ☐ I would like to receive correspondence via email/text

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired Employer/Occupation: ______________

Student Status: ☐ Full Time ☐ Part Time School/Address: ______________

Emergency Contact Name: __________ Phone #: __________ Relationship: __________

Whom may we thank for referring you to our office? ______________

RESPONISBLE PARTY (if someone other than the patient is responsible for billing)

First Name: ______________ Last Name: ______________ Middle Initial: ______

Address: ______________ City: __________ State: ____ Zip: ______

Home phone: __________ Cell: __________ Work: __________ Ext: ______

Birth Date: ___/___/_____ Age: _____ SS #: _____-_____-_____ Driver's License #: __________ State: _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Partnered ☐ Separated ☐ Widowed ☐ Minor

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired Employer/Occupation: ______________

PERMISSION TO RELEASE INFORMATION

I give permission to **PearlFection Dentistry** to give Clinical, Personal and Financial information in regards to my treatment to:

Name: ______________ Relationship: __________ Phone: __________

Name: ______________ Relationship: __________ Phone: __________

INSURANCE INFORMATION

Primary Insurance:

Name of Insured: ______________ Patient Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured SS #: _____-_____-_____ Insured Birth Date: ___/___/_____ Insured Employer: ______________

Insurance Company: ______________ Subscriber ID#: ______________ Group #: __________

Secondary Insurance:

Name of Insured: ______________ Patient Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured SS #: _____-_____-_____ Insured Birth Date: ___/___/_____ Insured Employer: ______________

Insurance Company: ______________ Subscriber ID#: ______________ Group #: __________

I certify that I, and/or my dependent(s) have insurance coverage with the company/ies stated above and assign directly to PearlFection doctors 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.

Signature of Patient, Parent or Guardian: ______________________ **Date:** __________

Updated 5-23-16

MEDICAL HISTORY

Although dental professionals primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following:

Patient First Name: ______________________ Last Name: ______________________ Middle Initial: ______

PHYSICIAN

Physician Name/Location: ____ Date of last visit: ____________

HEALTH CONDITIONS – Please check the conditions you have or have had & provide the date of when you had the condition.

☐ Abnormal Bleeding	☐ Cold sores	☐ Hepatitis	☐ Mitral valve prolapse
☐ AIDS	☐ Diabetes- A1C Level ___	☐ Herpes	☐ Neurologic condition
☐ Alcoholism	☐ Drug dependency	☐ High blood pressure	☐ Pacemaker
☐ Allergies	☐ Emotional condition	☐ High cholesterol	☐ Rheumatic fever
☐ Anemia	☐ Epilepsy	☐ HIV positive	☐ Rheumatic heart disease
☐ Arthritis	☐ Fainting spells	☐ Hives	☐ Seizures
☐ Artificial joint	☐ Frequent headaches	☐ Kidney disease	☐ Sinus trouble
☐ Artificial valve	☐ Hayfever	☐ Liver disease	☐ Stroke
☐ Asthma	☐ Heart ailment	☐ Low blood pressure	☐ Tuberculosis
☐ Blood disorders	☐ Heart angina	☐ Low cholesterol	☐ Tumor
☐ Blood transfusion	☐ Heart defect	☐ Lung problems	
☐ Cancer	☐ Heart murmur	☐ Migraine headaches	

Date/details of any conditions you have experienced:

____
____
____

HEALTH CONDITION QUESTIONS – Please answer the following questions based on your health & sleep.

Do you smoke or use chewing tobacco? ☐ Yes ☐ No   Joint replacement? ☐ Yes ☐ No   Where/When? ____________

Has anyone told you that you snore? ☐ Yes ☐ No   Have you ever been told that you stop breathing during sleep? ☐ Yes ☐ No

Have you been hospitalized in the last year? ☐ Yes ☐ No   If so, what is the reason? ____________________

MEDICAL LIST – Please list your current medication & the reason. Continue on back if you need more room or attach a list.

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

ALLERGY LIST – Please list any allergies (latex, medication, etc.)

______________________________ ______________________________
______________________________ ______________________________

WOMAN – Please answer the following questions.

Are you pregnant? ☐ Yes ☐ No   Expected delivery date? __________   Are you taking Birth Control or Hormones? ☐ Yes ☐ No

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in my medical status.

Signature of Patient, Parent or Guardian: ______________________________ **Date:** ____________

Updated 5-23-16

DENTAL HISTORY

Please provide us with details on your dental history and your thoughts on your smile.

Patient First Name: ______________________ Last Name: ______________________ Middle Initial: ______

DENTAL CONDITIONS – Please answer & mark any conditions you have/have had & provide the date of when you had the condition.

Name/Location of previous dentist: ______________________ Date of last dental visit: ____________

Are you apprehensive about dental treatment?	☐ Yes	☐ No
Have you had problems with previous dental treatment?	☐ Yes	☐ No
Do you gag easily?	☐ Yes	☐ No
Do you wear dentures?	☐ Yes	☐ No
Do you chew on only one side of your mouth?	☐ Yes	☐ No
Do your gums bleed easily?	☐ Yes	☐ No
Are your teeth sensitivite (to hot or colds)?	☐ Yes	☐ No
Do you clench or grind your jaws & do they feel tired?	☐ Yes	☐ No
Do you have a temporomandibular (jaw) disorder (TMJ)?	☐ Yes	☐ No
Do you use cigarette, cigar, pipe or chewing tobacco?	☐ Yes	☐ No

How often do you brush? ______________________

How often do you floss? ______________________

PERSONALIZED SMILE EVALUATION

Please take a moment to look at your teeth and gums carefully and then answer the following questions.
Your answers are personal and held in strict confidence.

1. On a scale 1-10, how do you feel about your teeth and smile? (1-worst, 10-best) ______________________

2. Are your teeth crooked or crowded and is that a concern? Please comment. ______________________

3. Do you have any spaces between your teeth that bother you? ______________________

4. Do you like the color of your teeth? Please comment. ______________________

5. Do you like the shape of your teeth? Please comment. ______________________

6. What would you like to change about the appearance of your smile? ______________________

7. Have you ever considered how you might feel with a brighter smile? Please comment. ______________________

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in my medical status.

Signature of Patient, Parent or Guardian: ______________________ **Date:** ____________

Updated 5-23-16

FINANCIAL POLICY

Thank you for choosing Pearlfection Dentistry. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of that mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

Cash, Check, Visa, Mastercard, American Express, Discover Card or Care Credit.

Pearlfection Dentistry requires payment at the beginning of your treatment. For larger, more comprehensive treatment plans, a 50% deposit is required to secure your initial treatment appointment. A non-refundable charge of $200 is required to reserve specialist appointments.

A fee of $50 is charged for patients who miss or cancel within less than 24 hours without notice. Pearlfection Dentistry charges $35 for returned checks.

For patients with dental insurance: we are happy to work with your carrier to maximize your benefit and we will directly bill them for reimbursement for your treatment. Patient are always responsible for 100% of fees not paid by insurance.

A credit card is required to be kept on file for patient balances. Charges $50 and less will be applied automatically, I authorize this charge without further notice. Patients will be notified prior to credit card processing over $51.

Assignment of Benefits: I hereby assign all dental benefits, to include major medical benefits to which I am entitled. I authorize and direct my insurance carrier(s) to issue payment check(s) directly to Pearlfection Dentistry for dental services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

If you have any questions, please do not hesitate to ask. We are here to help you receive the dentistry you want or need.

We provide an estimate based on limited information obtained from your insurance company. ***We expect you to pay your estimated share of the total fee at your visit.*** Dental insurance rarely pays all of the charges, and you are always responsible for the total amount.

PAST DUE BALANCE – INTEREST RATE

We reserve the right to charge 8% interest on past due balances beginning 30 days past the due date. We will charge $10 per statement sent out after the first statement has been sent out.

AUTHORIZATION AND RELEASE

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 information to the above-named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

Patient/Guardian Signature: ______________________________ Date: ______________

Print Name: ______________________________ Relationship to Patient: ______________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____________________________, have received a copy of this office's Notice of Privacy Practices.

Patient's Signature/Guardian's Signature	PRINT Patient's Name
PRINT Guardian's Name	DATE

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign.
- ☐ Communications barrier prohibited obtaining the acknowledgement.
- ☐ An emergency situation prevented us from obtaining acknowledgement.
- ☐ Other (please Specify) ____