PATIENT REGISTRATION FORM

Patient Information

The following information is vital to allow us to provide appropriate care for you, and for insurance verification purposes. Your information will be kept confidential subject to applicable laws.

First Name:_____ MI_____ Last Name_____

Preferred Name: _____ Gender: **M F** Preferred Gender: _____ Date of Birth: _____

Social Security #_____ E-mail: _____

Address: _____ Unit/Apt #_____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Marital Status: (circle) Married Divorced Legally Separated Widow Single

Employer: _____Occupation: _____ Business Phone: _____

Emergency Contact: _____Relationship: _____Phone: _____

How did you hear about us? _____

Responsible party (If self is selected, please skip to next section)

Self Spouse Father Mother Other: _____

First Name: _____Last Name: _____ Social Security # _____

Birth Date: _____Age: _____ Telephone: _____

Address: _____ City: _____State: _____Zip Code: _____

Employer: _____ Business Phone_____

Insurance Information

Primary Dental Insurance Company

Primary Policy Holder First Name: _____ Last Name: _____

Relation: _____Gender: **M F** S.S # _____ Insurance Co. Name: _____

Policy ID # _____ Group #_____Plan Name: _____

Secondary Dental Insurance Company

Primary Policy Holder First Name: _____ Last Name: _____

Relation: _____Gender: **M F** S.S # _____ Insurance Co. Name: _____

Policy ID # _____ Group #_____Plan Name: _____

Dental History

What is the reason for today's visit? _____

Previous dentist's name: _____ Date of last dental visit: _____

Health History

Are you under the care of a physician? If yes, please complete line below. Yes No

Date of Last Visit: _____ Physician Name: _____ Physician Phone: _____

Have you been a patient in the hospital during the past five years? Yes NO

Preferred Pharmacy: _____ Pharmacy Location: _____ Pharmacy Phone : _____

For Women Only

Are you pregnant? **Yes No** If yes, number of weeks: ____ Are you nursing? **Yes No**

Are you taking birth control pills? **Yes No (Antibiotics such as penicillin may alter the effectiveness of birth control pills. Consult your physician for assistance regarding additional methods of birth control.)**

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

	Y	N		Y	N		Y	N
Abnormal Bleeding			Fever Blisters			Pacemaker		
Alcohol Abuse			Frequent Headaches			Psychiatric Care		
Allergies			Glaucoma			Radiation Treatment		
Anemia			Head Injuries			Respiratory Problems		
Arthritis			Heart attack/Failure			Rheumatic Fever		
Artificial Joints			Heart Defect			Rheumatism		
Artificial Heart Valve			Heart Disease			Seizures		
Asthma			Heart Murmur			Sickle Cell Disease		
Blood Disease			Hepatitis A			Sinus Problems		
Blood Transfusion			Hepatitis B			Stroke		
High Blood Pressure			Hepatitis C			Thyroid Problems		
HIV/AIDS			Jaundice			Sleep Apnea		
Jaw Joint Pain			Kidney Disease			Tobacco Use		
Liver Disease			Low Blood Pressure			Tuberculosis		
Mitral Valve Prolapse			Cancer			Tumors/Growths		
Diabetes			Drug abuse			Ulcers		
Epilepsy			Fainting			Venereal Disease		

*Is there any disease, condition, or problem that you think our office should know about that is not listed above? If yes, please list below.

Do you require Pre-Med? **Yes** **No**

Medications

Please list all medication, over the counter and herbal supplements, that you are currently taking. (Include medication name, dosage, and frequency)

Allergies

Are you allergic to, or had a reaction to any of the following? (Please circle if yes)

Amoxicillin **Codeine** **Aspirin** **Erythromycin** **Dental Anesthetics** **Latex** **Penicillin** **Metals**

Sulfa Drugs **Tetracycline**

Please list any allergy/reaction that you have or had that is not listed above.

_____

Is there any information, or anything about your oral health you would like to tell us?

I understand the above information is necessary to provide me with dental care in a safe and effective manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the dentist of any changes in my Health or Medication.

Printed Name of Patient, Parent or Guardian: _____

Signature of Patient, Parent or Guardian: _____ Date: _____

Signature of Dentist: _____ Date: _____

Consent For Treatment

Please Initial

1. _____
   I authorize the dentist (s) to perform diagnostic procedures (i.e., radiographs, study models, photography, or other diagnostic aids) and treatment as may be necessary for proper diagnosis, planning and dental care.
2. **_____**
   I understand and consent to having photographs, radiographs, study models and other diagnostic aids that are part of my clinical record to be utilized for illustrative and educational purposes in research, lectures, and publications my dentist deems proper.
3. _____
   I understand that a fee may be charged for broken appointments as well as appointments canceled with less than a 24-hour notice.
4. _____
   I authorize the release of any information concerning my healthcare, advice and treatment to another dentist, physician, or healthcare professional and/or insurance company to secure payment benefits.
5. _____
   I understand that all professional services are charged directly to the patient and aim responsible or payment of fees, including all collection/attorney fees.

Patient or Responsible Party: _____ Date: _____

CONSENT TO RECIEVE MOBILE COMMUNICATION

By checking the below box and signing, I agree to enroll in Rooted Dental's mobile communication and online bill pay service Quick Bill.

I give my consent to receive important reminders, bill statements and benefits via automated SMS and email from Rooted Dental Co and Quick Bill.

This is an optional service and is not required to receive dental treatment.

I agree to receive text messages/email and use of online bill pay

_____

Patient/Guardian/Legally Authorized Representative Date

_____

Printed Name Relationship (if other than patient)

*Standard message and data rates may apply based on carrier rates and plans.

Financial Policy & Broken Appointment Policy

Financial Policy

Thank you for choosing Rooted Dental for your dental needs. In an effort to provide quality care to our patients and to avoid misunderstanding, we would like to inform you of our office policy regarding payment for services rendered. Payment is expected at the time treatment is performed. As a courtesy to our patients with dental benefits, we will submit your claim to your insurance company. Any portion not expected to be covered by these benefits is the responsibility of the patient due at the time service is rendered. This amount will include deductibles and co-payments. If actual benefits paid by insurance company are less than expected, you will be billed the difference when monthly statements are done.

Dental benefits are contracts between the policy holder and the insurance company, not out office.

We will make every effort to assist you with any benefit questions, however we suggest that you be aware of what benefits you have available. Ultimately, you are responsible for the balance.

Broke Appointment Policy

We would like our patient to understand that missed or broken appointments are hurtful in many ways. First, they delay your treatment and our ability to keep your oral health at optimum levels. Second, they may prevent another patient who needs treatment from getting necessary care. Our office understands that sometimes emergency situations arise, and we will handle each circumstance on an individual basis. With this in mind, we want you to be informed of our appointment policy.

-We require 48-hour notice for cancellation or rescheduling any appointments scheduled. If 48 hours is not given, a $25.00-$50.00 broken appointment fee may be charged depending on appointment type.

Thank you for your cooperation and, as always, we remain committed to your oral health.

Print Name:_____

Signature of (Patient, Parent, or Legal Guardian): _____

Date:_____

Acknowledgement of Receipt of Notice of Privacy Practices

Rooted Dental Company

_____

* You May Refuse to Sign This Acknowledgment*

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

Print Name:_____

Signature:_____

Date:_____

I hereby give my permission to discuss all aspects of my dental treatment to the

Individuals listed below:

____ Mother

____ Father

____ Son

_____ Daughter

_____ Husband

_____ Wife

_____ Other (Please Specify) _____

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 barriers prohibited obtaining the acknowledgement

€ An emergency situation prevented us from obtaining acknowledgement

€ Other (Please Specify)

Office Staff Initials: _____