PATIENT REGISTRATION

First Name: Last Name: Middle Initial:

Preferred Name:

Responsible Party: (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip:

Home Phone: Work Phone: Cell Phone:

Birth date: Social Security #: Drivers Lic#:

○ Responsible Party is Policy Holder for Patient ○ Primary Policy Holder ○ Secondary Policy Holder

Patient Information:

Address: Address 2:

City, State, Zip:

Home Phone: Work Phone: Cell Phone:

Sex: ○ Female ○ Male Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth date: Social Security #: Drivers Lic#:

E-mail: □ I would like to receive email correspondences

Patient Information (section 2):

Employment Status: ○ Full Time ○ Part Time ○ Self Employed ○ Retired ○ Unemployed

Student Status: ○Full Time ○ Part Time

Preferred Dentist: Preferred Hygienist: Preferred Pharmacy:

Referred By:

Emergency Contact:

Name: Relationship: Phone:

Name: Relationship: Phone:

Primary Insurance Information:

Name of Insured: Relationship to Insured: ○Self ○Spouse ○Child ○ Other

ID: Group # Insured SS #: Insured Birth date:

Employer: Insurance Company:

Secondary Insurance Information:

Name of Insured: Relationship to Insured: ○Self ○Spouse ○Child ○ Other

ID: Group # Insured SS #: Insured Birth date:

Employer: Insurance Company:

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a 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 questions.

Are you under a physician's care now?	Yes	No	If yes, please explain: _____
Have you ever been hospitalized or had a major operation?	Yes	No	If yes, please explain: _____
Have you ever had a serious head or neck injury?	Yes	No	If yes, please explain: _____
Are you taking any medications, pills, or drugs?	Yes	No	If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux?	Yes	No	
Are you on a special diet?	Yes	No	
Do you use tobacco?	Yes	No	
Do you use controlled substances?	Yes	No	
Do you need to pre-medicate?	Yes	No	If yes, please explain: _____

Women: Are you Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other If yes, please explain:

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

AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Renal Dialysis	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Rheumatic Fever	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Rheumatism	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Scarlet Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Shingles	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	Hives or Rash	Yes	No	Sickle Cell Disease	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hypoglycemia	Yes	No	Sinus Trouble	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Irregular Heartbeat	Yes	No	Spina Bifida	Yes	No
Asthma	Yes	No	Fainting Spells/Dizziness	Yes	No	Kidney Problems	Yes	No	Stomach/Intestinal Disease	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Leukemia	Yes	No	Stroke	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Liver Disease	Yes	No	Swelling of Limbs	Yes	No
Breathing Problem	Yes	No	Frequent Headaches	Yes	No	Low Blood Pressure	Yes	No	Thyroid Disease	Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Lung Disease	Yes	No	Tonsillitis	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Mitral Valve Prolapse	Yes	No	Tuberculosis	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Pain in Jaw Joints	Yes	No	Tumors or Growths	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Murmur	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disorder	Yes	No	Heart Pace Maker	Yes	No	Radiation Treatments	Yes	No	Yellow Jaundice	Yes	No
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Recent Weight Loss	Yes	No			

Have you ever had any serious illness not listed above? Yes No If yes, please explain:

_____

_____

_____

Comments:

_____

_____

_____

_____

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 patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Smile Evaluation

A Simple Evaluation to Help You Obtain the Smile You've Always Wanted

Hold a mirror 12"–14" from your face. Smile to show your teeth. Take the time to observe your teeth carefully, and then answer the following questions:

1 Do you like the appearance of your teeth and your smile? ☐Yes ☐ No
If not, explain _____
_____

2 Are your teeth all in alignment (straight)? ☐ Yes ☐ No
If not, explain _____
_____

3 Do you have spaces that you don't like? ☐ Yes ☐ No
If yes, explain _____
_____

4 Do you like the color of your teeth? ☐ Yes ☐ No
If not, explain _____
_____

5 Do you like the shape of your teeth? ☐ Yes ☐ No
If not, explain _____
_____

6 Are your teeth…
Chipped ☐ Yes ☐ No Protruding ☐ Yes ☐ No Hidden ☐ Yes ☐ No
If yes, explain _____
_____

7 Are your teeth wearing on the biting surfaces? ☐ Yes ☐ No
If yes, explain _____
_____

8 Are there old fillings or dental work you don't like looking at? ☐ Yes ☐ No
If yes, explain _____
_____

9 What would you like to change the most in the appearance of your teeth?
_____
_____

10 How would you like your teeth to look?
_____
_____

If you are not happy with the appearance of your teeth, ask your dentist how they can improve your smile.

Financial Policy

We are committed to providing you with the best care possible. If you have dental insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy. Payment for services are due at the time services are rendered. We accept cash , check, visa, mastercard and discover payments. We will be happy to process any insurance claims for you. We will do our very best to accurately **ESTIMATE** what your insurance company will pay toward normal services.

Please understand however, our calculations are strictly **ESTIMATES** and are no guarantee that your insurance company will reimburse us according to these estimates. Ultimately, your insurance is a contract between you and your insurance carrier. We are not a party to that contract. Any service that is not covered by your insurance company, for whatever reasons, is your financial responsibility.

Returned Checks are charged according to the bank's fees and balances older than 30 days will be subject to additional collection fees and interest charges. A charge of $50.00 may also be applied for broken appointments and appointments cancelled without 48 hours advance notice,

Any attorney or collection fees incurred due to delinquency in payment will also be charged to patient.

I hereby acknowledge that I have read this document and understand my financial responsibility for dental services provided for myself and other patients whose names I have provided to appear on my account with So-Well Dental Associates.

SIGN:_____DATE:_____

Consent for Treatment

Upon agreement to treatment I hereby grant authority to the dentist(s) and/or her designated staff in charge of the care of the patient whose name appears on this Health History form, to administer such anesthetics, analgesics, sedatives, and intravenous sedation; and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics and/or drugs.

All services are rendered and accepted under the terms and conditions listed above.

In order to proceed with any treatment, authorization must be signed by the patient, or by the nearest relative in the case of a minor or when the patient is physically or mentally incompetent.

Print Name:_____ D.O.B: _____
Signature:_____ Date: _____ Relationship to Patient_____

So-Well Dental Associates

Acknowledgement of Receipt of Notice of Privacy Practices

You may refuse to sign this acknowledgement

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

_____
Please Print Name

_____
Signature

_____
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 barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____
_____
_____

OralID™
Shine Light. Save Lives.

Consent Form – Oral Cancer Screening

Our office strives to bring its patients state-of-the-art technology to provide you with the latest advancements in oral health. We have recently introduced the OralID™ screening device into our office. The OralID™ examination will allow us to visualize any oral mucosal abnormalities including cancer and dysplasia (pre-cancer) before they can be detected with the naked eye. The procedure is quick, painless and no rinses or dyes are used.

Similar to other cancers, early detection of Oral Cancer is critical. Studies have shown that early detection of oral cancer with technologies like the OralID™ dramatically improves the survivability of the disease. If oral cancer is detected in its later stages, which typically occurs during a conventional oral cancer exam, the chances of survival are dramatically reduced.

Who is at Risk?

- Age - 17+ years
- Tobacco Use
- Alcohol Use
- HPV infection

If you have any questions about risk factors, please feel free to talk to our hygiene staff. We recommend all of our patients be screened with the OralID™ to reduce the mortality of late stage detection.

Our office charges $_____ per screening with the OralID. We will attempt to bill your insurance, but you will be responsible for any unpaid amount or denial by your insurance company.

☐ Yes, I request that your staff perform an examination with the OralID. I accept financial responsibility for this examination.

_____ _____ _____
Signature Name Date

☐ No, I prefer to not have this examination at this visit.

_____ _____ _____
Signature Name Date

OralID® CytID® hpvID® PathID® FS FORWARD SCIENCE phID® SalivaMAX® SalivaCAINE®

FS-842 v1.0