

ADULT REGISTRATION

Patient Name _____ Today's Date _____
Name you wish to be addressed by _____ Birthdate _____ SS# _____
Mailing Address _____ City _____ State _____ Zip _____
Street Address (if different) _____
Telephone: Home _____ Cell _____ Other _____
Marital Status: Single _____ Married _____ Divorced _____ Separated _____ Widowed _____
Your Employer _____ Work Phone _____
Spouse Name (if applicable) _____
Spouse's Employer _____ Work Phone _____
Name you wish this account placed in _____
Address (if different) _____

In case of an emergency, please list the name of a friend or relative whose telephone number is different than yours

Name _____ Relationship _____
Address _____ Telephone _____

Who may we thank for referring you to our office? _____

DENTAL INSURANCE INFORMATION

Dental Insurance #1

Subscriber _____ Birthdate _____
Employer _____ SS# _____
Insurance Company Name _____
Subscriber ID # _____ Group# _____

Dental Insurance #2

Subscriber _____ Birthdate _____
Employer _____ SS# _____
Insurance Company Name _____
Subscriber ID # _____ Group# _____

Our office policy is to accept payment at the time services are rendered unless arrangements are made in the front office in advance. We file your dental insurance as a courtesy to you. **You are ultimately responsible for payment for all your dental care.**

I authorize the release of any information necessary to process my insurance claim.

X _____

I hereby authorize payment directly to the dentist of the insurance benefits otherwise payable to me. A copy of this signature is as valid as the original.

X _____

I understand and agree that any credit granted shall be paid promptly in accordance with terms and agreements, that the credit grantor may add one and one half percent (1.5%) per month to any balance owed after ninety (90) days, and in the event of default to pay reasonable collection charges and/or attorney fees.

X _____

Health History

MEDICAL HISTORY

Patient's Name _____ Today's Date _____

Physician's Name _____ Date of last physical exam _____

Do you have or have you had any of the following: Please indicate with check mark (✓).

___ Any heart problems	___ Asthma	___ Sinus Problems
___ High blood Pressure	___ Diabetes	___ Stroke
___ Low blood Pressure	___ Hepatitis	___ Tuberculosis
___ Circulatory problems	___ Herpes	___ Ulcer
___ Nervous problems	___ Malignancies	___ Venereal Disease
___ Radiation treatments	___ Measles	___ Anemia
___ Excessive bleeding	___ Mumps	___ Arthritis
___ HIV/AIDS	___ Rheumatic Fever	___ Other

Are you Pregnant _____
Are you allergic to medicines
or drugs? _____

Please List Allergies:

Are you allergic to anesthetics?

Are you currently taking blood thinners (i.e. Coumadin, aspirin) _____

Do you have artificial: pins, plates, valves, or joints? _____ If yes, do you need to take pre medication before teeth cleanings or extractions? _____

Please list all medications you are currently taking: (if you have a current list, we can make a copy)

Please describe any current medical or dental treatment and impending operations:

Date _____

Your Signature _____

DENTAL HISTORY

Are you having any discomfort at this time _____

How long since you have been to a dentist _____

What was done then _____

Previous Dentist _____

Did you have X-rays _____

Have you lost any teeth _____

Why _____

Any complications with extractions _____

Are your teeth sensitive: to heat _____ to cold _____
to sweets _____ to sour _____

How often do you brush your teeth _____

When _____

Do you use dental floss _____ How often _____

Do you have bleeding gums _____

Have you had your teeth straightened _____

When _____

Do you grind or clench your teeth _____

When _____

Do you feel you have bad breath at times _____

Unpleasant taste in mouth _____

Are you aware of any swelling or lump in your mouth _____

Do you have any fear of having dentistry done _____

If yes, why _____

Do you want to avoid denture's _____

Do you want to know how you can keep the natural teeth you
still have _____

If you have children, do you want to learn how they may keep
their natural teeth for a lifetime without discomfort _____

Payment/No Show Policy

Insurance Acceptance Guidelines:

As of June 30th, 2026 our office will no longer be participating with any insurance companies. Please be advised that at the time of your appointment, payment in full may be expected.

We are out of network with all other insurances. As a courtesy to the patient we will bill all insurance policies that are out of network.

The patient is responsible for all co-insurance and deductibles.

Unpaid balances:

Any unpaid balances on your account: Your account will be put on hold until balance is paid in full, no dental appointments will be made while balance remains.

We can take credit/debit card payments over the phone. We are offering Cherry for any payment plans for the office. Please ask the front desk if interested.

No Show Appointments:

\$50 non-reimbursable charge. Unfortunately this has become a huge issue at our office.

We classify a missed/no show appointment as being an appointment where there is not enough time to fill the appointment with another patient in need of services. If we are able to fill your appointment no charge will be filed. A 5-minute notice is not enough time to fill your appointment.

We give a courtesy call within 48 hours to all of our patients personally, leave messages to confirm, and you most likely have an appointment card. **Please call us back to confirm your appointment!** If you think you have an appointment but did not receive a phone call within 48 hours of this appointment please call us.

Please sign this form below to acknowledge that you have read over all of our policies. Thank you!

Patient Signature/Parent or Guardian Signature

Date

Patient Printed Full Name

PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day-to-day healthcare operations of your practice

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print Patient Name: _____

Relationship to patient (if applicable): _____

Signature: _____ Date: _____

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