PATIENT REGISTRATION

Date: ____/____/____

Patient Information

SECTION 1

Name: _____ ☐ Single ☐ Married ☐ Minor
Last First Middle

Birth Date: ____/____/____ SS# ____-____-____ ☐ Female ☐ Male

Home Address: _____
Street Apt# City State Zip

Occupation: _____ Employer/School: _____

Home # (____) _____ Preferred Contact ☐ Home ☐ Work ☐ Cell ☐ Email ☐ Text

Cell # (____) _____ Email Address: _____

Work/School # (____) _____ Ext _____

If other than "self"

Person Responsible for Account _____ Relationship: _____

SS # ____-____-____ Birth Date: ____/____/____

Home Address (if different): _____ Zip _____

Home # (____) _____ Work # (____) _____

Occupation: _____ Employer: _____

Referred By: _____ Date of Last Dental Visit : _____

Do you have Dental Insurance? Yes ☐ No ☐ Insurance Company: _____

Are you currently having dental problems? _____

What are your concerns? (Check as many as applicable)

- ☐ Pain Avoidance
- ☐ Appearance
- ☐ Losing Teeth
- ☐ Gum/Periodontal Disease Cavities
- ☐ Oral Cancer
- ☐ Wasting/Exceeding Dental Insurance Limits
- ☐ Your General Health
- ☐ Routine Checkup
- ☐ Cleaning
- ☐ Other

Emergency Information

Outside of Immediate Family/Household

Name _____

Telephone # _____

Method of Payment:
Patients will be expected to pay for services when treatment is rendered.
Visa/MasterCard/Amex/Discover/Check/Cash are accepted.

☐ I wish to discuss interest free financing with Care Credit

If you have insurance, we will help you to determine the coverage you have available. We ask that you assign your insurance benefits to us. Professional care is provided **to you, our patient, and not to an insurance company**. Thus, the insurance company is responsible to the patient and the patient is responsible to the doctor. We will help in every way we can in filing your claim and handling insurance questions from our office on your behalf. However, insurance balances 60 days and over are **due in full from the patient**.

I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the dental office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals. I realize a responsible adult (parent or guardian) must remain in the office while treating a minor.

In connection with dental services which I am receiving, I consent that photographs may be taken of me, for the explicit use of dental research, education, training or science; provided, however, that it is specifically understood that in any such publication or use I shall not be identified by name. I waive all rights that I may have to any claims for payment or royalties in connection with any exhibition, televising, or other showing of the photographs regardless of whether such use of said photographs is commercial, institutional or private sponsorship, and irrespective of whether any fee or charge is received.

Signature: _____ Date: _____

☐ Adult Patient ☐ Father ☐ Husband ☐ Mother ☐ Wife ☐ Guardian

Doctor Signature: _____ Date: _____

SECTION 2

Medical History

Yes No

Are you under a physician's care now? Who? _____ Date of last physical: _____ ☐ ☐

Have you ever been hospitalized or had an operation? _____ ☐ ☐

Have you ever had a serious injury to your head or neck? Describe _____ ☐ ☐

Are you taking any medications, pills or drugs? (Include illegal/recreational drugs) What? _____ ☐ ☐

_____

Are you on a special diet? Describe _____ ☐ ☐

Are you allergic to any medications or substances? Please check box for allergic reaction below _____ ☐ ☐

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex Rubber ☐ Other _____

Women (Please check): ☐ Pregnant/trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives

Describe _____

Do you have or have you ever had any of the following:

(*If yes to any of the * starred conditions, please call prior to your appointment...pre-medicatons may be required)

	Yes	No		Yes	No		Yes	No		Yes	No
ADD/ADHD	☐	☐	Diabetes	☐	☐	Hepatitis C	☐	☐	Renal Dialysis	☐	☐
AIDS*	☐	☐	Drug Addiction/Use	☐	☐	Herpes (Cold Sore)	☐	☐	Rheumatic Fever*	☐	☐
Alcohol Use/Abuse	☐	☐	Emphysema	☐	☐	High Blood Pressure	☐	☐	Rheumatism	☐	☐
Anemia	☐	☐	Excessive Bleeding	☐	☐	HIV Positive	☐	☐	Scarlet Fever*	☐	☐
Angina/Chest Pain	☐	☐	Excessive Thirst	☐	☐	Hypoglycemia	☐	☐	Seizure	☐	☐
Arthritis/Gout	☐	☐	Fever Blisters	☐	☐	Irregular Heart Beat	☐	☐	Shortness of Breath	☐	☐
Artificial Heart Valve*	☐	☐	Frequent Cough	☐	☐	Kidney Problems	☐	☐	Sickle Cell Disease	☐	☐
Artificial Joints*	☐	☐	Frequent Diarrhea	☐	☐	Leukemia	☐	☐	Sinus Trouble	☐	☐
Asthma	☐	☐	Genital Herpes	☐	☐	Liver Disease	☐	☐	Snoring/Sleep Apnea	☐	☐
Blood Disease	☐	☐	Hay Fever	☐	☐	Low Blood Pressure	☐	☐	Stomach/Intestinal Disease	☐	☐
Breathing Problems	☐	☐	Heart Attack/Failure	☐	☐	Lung Disease	☐	☐	Stroke	☐	☐
Bruise Easily	☐	☐	Heart Murmur/Surgery *	☐	☐	Mitral Valve Prolapse*	☐	☐	Swelling of Limbs	☐	☐
Cancer	☐	☐	Heart Pace Maker*	☐	☐	Pain in Jaw Joints	☐	☐	Thyroid Disease	☐	☐
Chemotherapy	☐	☐	Heart Trouble/Disease	☐	☐	Parathyroid Disease	☐	☐	Tuberculosis	☐	☐
Congenital Heart Disorder	☐	☐	Hemophilia (Bleeding Problems)	☐	☐	Radiation Therapy	☐	☐	Ulcers	☐	☐
Cortisone Medicine	☐	☐	Hepatitis A & C (infectious)	☐	☐	Recent Blood Transfusion	☐	☐	Venereal Disease	☐	☐
Depression	☐	☐	Hepatitis B (Serum)	☐	☐	Recent Weight Loss	☐	☐	Yellow Jaundice	☐	☐

Yes No

Have you ever had any other serious illness not checked above? Describe _____ ☐ ☐

Do you wish to talk to the dentist privately about any problem? _____ ☐ ☐

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail I will inform the doctor promptly of any medications legal or illegal, prescription or non-prescription that I am taking.

In Accordance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), a NOTICE that describes how medical information about you may be used and disclosed and how you can get access to this information is posted in the RECEPTION room. Should I desire to have a printed copy of this NOTICE, I will check the following box and notify the RECEPTIONIST: ☐ ***I DO WANT A COPY OF 'NOTICE'*** ☐ ***I DO NOT WANT A COPY OF 'NOTICE'***

Signature: _____ Date: _____

☐ *Adult Patient* ☐ *Father* ☐ *Husband* ☐ *Mother* ☐ *Wife* ☐ *Other*

Reviewed by Doctor _____ Date: _____ BP _____

History review and significant findings: _____

Patient's Name:_____ Date: _____

PLEASE **INITIAL** EACH PARAGRAPH AFTER READING. A SEPARATE CONSENT WILL BE SIGNED IF YOU NEED TO HAVE ANY OF THE FOLLOWING PROCEDURES PERFORMED.

Drugs and Medications:

I understand that antibiotics, analgesics, anesthetics and other medications can cause allergic reactions, resulting in redness and swelling of tissues, itching, pain, nausea and vomiting or more severe allergic reactions, including heart irregularities. I have informed the doctor of any known allergies. Certain medications may cause drowsiness and impair judgment. It is advisable not to drive or operate hazardous equipment when using such drugs. I understand that pain medications are meant to dull the pain and take the edge off and may not be effective for pain eliminated.

TREATMENTS PERFORMED AT DENTAL ARTS OF WESTWOOD INCLUDE THE FOLLOWING:

_____1. **Sealants:**

I understand that sealants are meant to help prevent decay on the chewing surface of a tooth. A sealant is not guaranteed protection from decay. They may wear out and/or chip and may require periodic replacement. Typically not covered by adults.

_____ 2. **Fillings: White (Composite):**

I understand that a more extensive restoration than originally planned may be required due to additional conditions discovered during preparation. I realize that fillings are rarely "permanent" and usually require periodic replacement.

I understand any time a tooth is prepared, for any reason, there is always irritation to the nerve of the tooth, which may result in post-operative sensitivity or, in some cases, permanent nerve damage requiring root canal treatment or removal of the tooth. It is difficult to predict how your tooth may respond to treatment.

*****We do not use mercury (silver) colored fillings in this office. These fillings are more likely to crack the tooth because they expand and contract with the changing temperatures. We only use resin (white) colored fillings. Some insurance companies will only cover a percentage of the silver fillings and an additional charge may apply for a white filling. Please sign below stating you understand. *****

_____3. **Crowns and Bridges:**

I understand that it is sometimes not possible to exactly match the color of natural teeth with artificial teeth. I further understand that I may be wearing temporary crowns that are prone to loosening and may need re-cementing. I will notify my doctor of that occurrence so that a temporary restoration is maintained until the final restoration is delivered. I understand that crowns and bridges are not permanent and may require replacement in as little as three years and that brushing, flossing, and regular cleanings are essential. I realize that any changes I may desire in color, shape, size, etc. of a crown must be made prior to final placement of the restoration. It is my responsibility to return within one month of tooth preparation for final cementation of the restoration. I understand I may need additional treatment if complications arise during treatment, and any costs thus incurred are my responsibility. Additionally I understand that it is my responsibility to return within one month for a check to ensure that the crown or bridge has been placed to my satisfaction.

_____4. **Dentures (A SEPARATE CONSENT WILL BE SIGNED IF NEEDED):**

_____5. **Root Canal Therapy**

I realize there is no guarantee that root canal treatment will save a tooth, and that complications can occur from treatment. I understand that an undetectable "hairline" crack in a tooth may cause failure, no matter how extensive therapy may be. A small percentage of root canals fail despite the best efforts. I understand that specialty care may be indicated if complications arise, such as the need for an apicoectomy.

_____ 6. **Extractions, Alveoplasty and/or Torus Removal (See Consent for Extraction of Teeth/Alveoplasty):**

I understand that alveoplasty (also called an alveolaplasy) is a surgical procedure that smoothes the jawbone. It is done in areas

where teeth have been removed or lost. Alveoplasty can be done alone, but is usually done at the same time those teeth are extracted.

____7. **Bone Graft:**
I understand that the graft I will be receiving is derived from human bone that has been collected, stored, and processed according to the Standards for Tissue Banking of the American Association of Tissue Banks and Food and Drug Administration Regulations.

____8. **Periodontal Treatment**:
Periodontal disease can be a serious condition, causing gum and bone inflammation and/or loss and may lead to loss of permanent teeth. Possible treatment plans have been explained to me, including scaling and root planning (deep cleaning), gum surgery and bone grafting, extraction of teeth and tooth replacement. I understand that much of the success of periodontal treatment depends on my continuing home care and faithful adherence to following my doctor's instructions, including strict observance of cleaning appointments. I understand that care by a specialist may be necessary.

____9. **Apicoectomy/Endo Surgery (**A SEPARATE CONSENT WILL BE SIGNED IF NEEDED**):**

____10. **Implants (**A SEPARATE CONSENT WILL BE SIGNED IF NEEDED**):**

____11. **Gingivectomy**:
I understand a gingivectomy is the surgical removal of gingiva (gum tissue) around a tooth or teett1 to maintain general oral health. A gingivectomy can also be done cosmetically to remove excess gingiva. Some risks of a gingivectomy can be infection and/or bleeding at the surgery site. I further understand that regular check-ups and cleanings are essential in maintaining good oral health.

_____12. **Crown Lengthening:**
I realize that crown lengthening is one part in the process to save a tooth that has limited tooth structure above the gum line. I understand the surgical procedure may involve removal of gum tissue, bone or both to expose more of the tooth's structure. The healing time is usually 4-8 weeks before a permanent filling or crown can be placed. I may encounter bleeding, infection, and/or loosening of the tooth. During the healing process, I may experience hot and/or cold sensitivity.

_____13. **Gingival (Gum) Graft:**
I understand that grafts are typically placed in an attempt to reduce gum recession or prevent it from progressing. The graft is usually taken from another area within the mouth and is placed at or near the recession or problem area. Some risks include bleeding, pain, and infection. It is essential to have the graft checked at your regular cleaning appointments.

Changes in Treatment Plan:

I understand that during treatment it may be necessary to change or add procedures because of conditions discovered during treatment that were not evident during examination. I authorize my doctor to use professional judgment to provide appropriate care.

I understand that dentistry is not an exact science and that no specific results can be assured or guaranteed. I acknowledge that no such guarantees have been made regarding the dental treatment I have authorized. I understand that the treatment plan and fees proposed are subject to modification, depending upon unforeseen or undiagnosed conditions that may be recognized only during the course of treatment.

I understand that any associated fees are my financial responsibility.

I have given a complete and truthful medical history including all medicines, drug use, pregnancy, etc.

CONSENT: My signature below signifies that I understand the procedures above are the ones performed in this office. I hereby give my consent of my first dental appointment and sign this general consent allowing the doctor to have the opportunity to make a full treatment plan and take the necessary x-rays needed for proper diagnosing during my first visit at Dental Arts of Westwood.

_____ _____
Patient's (or Legal Guardian's) Signature Date

_____ _____
Witness Signature Date

HIPAA FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices.*

The best contact method for me is my cellphone and I consent to Dental Arts of Westwood to call, email and/or text my cell phone regarding treatment, insurance, and/or any other information regarding my account. I understand that I can withdraw my consent at any time.

My cell phone number is (include area code) _____ _____(initial)

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but If you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

DENTAL ARTS OF WESTWOOD FINANCIAL CONSENT

Thank you for choosing our office as your dental health care provider. We are committed to providing you with the highest quality lifetime dental care so that you may fully attain optimum oral health. Everyone benefits when office and financial policy arrangements are understood. In order that we may have a definite understanding in regard to the payment for dental services, the following is our policy.

Financial Obligation/Payment Policy: Payment is due at the time service is provided. For your convenience we accept cash, personal check, Cashier's Check, Visa, MasterCard, Discover, American Express and Care Credit. A fee of $25.00 will be charged for all returned checks. Delinquent balances are subject to additional finance charges, the collection process, and all costs incurred as a result of entering into the collection process. Any credit generated on your account will be applied to future treatment balances unless you contact us requesting a reimbursement check.

For patients with dental benefits, we require 20% of the treatment total at the time of service for basic restorative treatment (such as fillings) and 50% for major treatment (such as crowns, bridges, extractions, and root canal treatment). For preventative treatment (such as cleanings, diagnostic films, and exams), we do not require payment at the time service is rendered. As a courtesy to you, we will process all of your insurance claims. Insurance pre-estimates are not a guarantee of payment. We must emphasize that this is only an estimate, and all charges you incur are your responsibility regardless of your insurance coverage. Insurance companies have a wide variety of rules, plan limitations and exclusions that our office may not be aware of. Dental insurance is a benefit for the patient provided by their employer and the contract lies between the patient, employer and the insurance company. Our office is not a party to that contract. **It is the responsibility of the patient to know their specific plan/policy's coverage.** We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid, however this office will not enter into a dispute with your insurance company over any claim. Once insurance has paid their share, a statement will be sent to you, and we ask that any remaining balance be paid in full within 30 days. If your insurance company has not made payment within 60 days, the unpaid balance becomes your responsibility. A statement will be sent to you, and we ask that any remaining balance be paid in full within 30 days.

For patients without dental benefits, payment is required in full at the time services are rendered, unless alternative payment arrangements have been made ahead of time.

Separated & Divorced Couples with Dependent Children: It is the policy of this office to bill the parent who is listed as the guarantor on the account. Please make arrangements for payment from an ex-spouse before dental treatment is rendered. We can provide a treatment cost estimate before your child's scheduled appointment.

Cancellation & Late Policy: When our office books your appointment, we are setting aside a dedicated chair and time slot just for you. We only ask that if you must reschedule your appointment, that you please provide us with at least 48 hours notice. This courtesy makes it possible to give your reserved time slot to another patient who would be more than happy to accept.

There is a charge of $50.00 per hour for not showing up for scheduled appointments.

**Repeated cancellations or missed appointments will result in loss of future appointment privileges.*

Every patient in our practice receives this unique reservation. When your appointment is made, a time is reserved, your materials are ordered, and we make special arrangements to be ready for your visit. Except for emergency treatment for another patient, you can expect us to be prompt. We, of course, would appreciate the same courtesy from you.

Please take notice that this office policy will come into effect after your second cancellation without 48 hours notice.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our policies. Here at Dental Arts of Westwood, smiles are our business and every member of our team, is committed to yours.

Thank you for your understanding and we hope you have a great experience!

Dr. Dan and the Team at Dental Arts of Westwood

Person Responsible for Account_____Date:_____

Patient Name:_____Patient Signature:_____