CARMEL
Family Dentistry P.C.

PATIENT INFORMATION AND REGISTRATION

Patient Name: _____ SSN: _____ Date: _____

☐ Single ☐ Married ☐ Divorced ☐ Minor Gender: _____ Age: _____ Birth Date: _____

Name of person responsible for this account: _____ Relationship to patient: _____

Please select the method of payment you will be using, our office accepts the following:
☐ Cash ☐ Personal Check ☐ Credit Card (Visa, MasterCard) ☐ Care Credit

Email Address: _____

Mobile #: _____ Home #: _____ Work #: _____

Home Address: _____
Street Apartment #

_____
City State Zip Code

Your Employer/School: _____ Occupation: _____

REFERRAL INFORMATION

Whom may we thank for referring you to our practice?

☐ Friend ☐ Relative ☐ Internet/Google ☐ Insurance website ☐ Phone Book ☐ Doctor ☐ Other_____

Name of person/office referring you to our practice: _____

CANCELLATION POLICY

We understand that emergencies may arise that prevent you from keeping an appointment, but as our office strives to treat patients in a timely manner, we expect the courtesy to be returned. **A minimum 24 hour notification call must be given to avoid a $25.00 cancellation fee due to the inconvenience caused to the office.** Initials: _____

FINANCIAL POLICY

Thank you for choosing our office as your dental health care provider. We are committed to providing you with lifetime dental care so that you may attain optimum oral health. Please understand our following payment requirements.

Payment is due at the time services are rendered. Our office accepts cash, personal checks, MasterCard or Visa, and Care Credit. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid in full at the time services are rendered.
Please note that all returned checks will be subject to a $35.00 additional fee. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance; you will be responsible for any collection and/or legal charges incurred up to 35%.

As a courtesy to you, we process all your insurance claims. Also understand that we provide an insurance **estimate** to you, however it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid.
All charges you incur are your responsibility regardless of your insurance coverage. Your insurance policy is a contract between you, your employer, and your insurance company. Our office is not a party to that contract. We ask that you pay the deductable and co-payment, which is the estimated amount not covered by your insurance company, by any of our accepted means of payment options.

I understand that responsibility for payment for dental services provided in this office for myself or my dependants is mine, due and payable at the time services are rendered unless financial arrangements have been made. I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

MEDICAL HISTORY

Do you have any CURRENT HEALTH PROBLEMS? ☐ Yes ☐ No
If yes, please explain: _____

Are you under a PHYSICIAN'S CARE now? ☐ Yes ☐ No
Physicians Name: _____ Phone #: _____ Date of last visit: _____

Have you ever had or currently have any of the following? Please check all that apply:

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Arthritis/Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Bleeding Abnormally
- ☐ Blood Disease
- ☐ Breastfeeding
- ☐ Cancer
- ☐ Chemo/Radiation
- ☐ Circulation Problems
- ☐ Congenital Heart Disease
- ☐ Cortisone Treatments
- ☐ Cough
- ☐ Diabetes
- ☐ Depression
- ☐ Epilepsy/Seizures
- ☐ Fainting or Dizziness
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Headaches or Migraines
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Hepatitis Type___
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mental Disorders
- ☐ Mitral Valve Prolapse
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Pregnant
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Sinus Trouble
- ☐ Sleep Apnea
- ☐ Skin Rash
- ☐ STD
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Swollen Feet or Ankles
- ☐ Swollen Neck Glands
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Tumors

Do you smoke or use tobacco? ☐ Yes ☐ No
Do you use controlled substances? ☐ Yes ☐ No

MEDICATIONS

List any medications you are currently taking:

_____
_____
_____
_____
_____
_____

ALLERGIES

Please check all that apply:

- ☐ Aspirin
- ☐ Clindamycin
- ☐ Codeine
- ☐ Ibuprofen
- ☐ Latex
- ☐ Other _____
- ☐ Local Anesthetic
- ☐ Metals
- ☐ Penicillin
- ☐ Sulfa Drugs
- ☐ Tylenol

Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
If yes, please explain: _____

Do you have any health problems that need further clarification? ☐ Yes ☐ No
If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment without fail.

Signature (Patient/Parent/Guardian): _____ Date: _____

INSURANCE INFORMATION

Primary (if applicable)

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
(Last, First)

Insured's Birth Date: _____ Insured's SSN: _____

Insured's Address: _____
(Street, City, State, Zip Code)

Insured's Employer Name: _____

Employer's Address: _____
(Street, City, State, Zip Code)

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Dependant ☐ Other _____

Insurance Carrier Name and Address: _____

_____

ID #: _____ Group #: _____

Secondary (if applicable)

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
(Last, First)

Insured's Birth Date: _____ Insured's SSN: _____

Insured's Address: _____
(Street, City, State, Zip Code)

Insured's Employer Name: _____

Employer's Address: _____
(Street, City, State, Zip Code)

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Dependant ☐ Other _____

Insurance Carrier Name and Address: _____

_____

ID #: _____ Group #: _____

DENTAL HISTORY

Reason for today's visit: _____

Date of last dental visit: _____

Previous Dentist: _____ City/State: _____ Phone #: _____

Have you ever had or currently have any of the following? Please check all that apply:

- ☐ Bad breath
- ☐ Grinding/Clenching teeth
- ☐ Swollen or tender gums
- ☐ Bleeding gums
- ☐ Gum disease
- ☐ Periodontal (gum) surgery
- ☐ Sores in mouth
- ☐ Difficult extractions
- ☐ Orthodontic treatment
- ☐ Clicking or popping jaw
- ☐ Jaw pain or tiredness
- ☐ Lip or cheek biting
- ☐ Blisters on lips or mouth
- ☐ Sensitivity to sweets
- ☐ Loose or broken fillings
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to biting
- ☐ Burning sensation on tongue
- ☐ Dry mouth

How often do you brush? _____ How often do you floss? _____ Do you like your smile? ☐ Yes ☐ No