Registration

Downtown Periodontics and Implant Dentistry

Last Name:	First Name:	Today's Date:
Birthdate: Sex: M F Prefer not to answer	Please Circle: Married Single Divorced Partner Widowed	Social Security Number:
Street Address:	City, State, Zip Code:	Email Address:
Mobile Number:	Home/Work Phone:	Emergency Contact Name/#:

Dental Insurance (Primary)

Policy Holder Name:	ID or SSN:
Policy Holder Date of Birth:	Patient's Relationship to Policy Holder:
Insurance Company Name:	Claims Address:
Group Number:	

Secondary Insurance

Policy Holder Name:	ID or SSN:
Policy Holder Date of Birth:	Patient's Relationship to Policy Holder:
Insurance Company Name:	Claims Address:
Group Number:	

Signature on file Statement

I authorize the release of any information relating to claims for benefits submitted on behalf of myself and/or dependents. I further authorize Downtown Periodontics and Implant Dentistry to submit claims for benefits to my insurance carrier for services provided or to be provided without obtaining my signature on every claim submitted for myself and/or dependents. I will be bound by this signature as though I had personally signed the particular claim. I also authorize the assignment of benefits directly to the provider for services.

Policy Holder Signature and Date:

_____

Signature on file Statement

I authorize the release of any information relating to claims for benefits submitted on behalf of myself and/or dependents. I further authorize Downtown Periodontics and Implant Dentistry to submit claims for benefits to my insurance carrier for services provided or to be provided without obtaining my signature on every claim submitted for myself and/or dependents. I will be bound by this signature as though I had personally signed the particular claim. I also authorize the assignment of benefits directly to the provider for services.

Policy Holder Signature and Date:

_____

I have read a copy of this office's Notice of Privacy Practices which were supplied to me upon request.

Signature:_____ **Date:** _____

Downtown Periodontics and Implant Dentistry Financial Policy

Thank you for choosing us as your dental health care provider. We believe that all patients deserve the very best dental care we can provide. We also believe that everyone benefits when specific financial arrangements are agreed upon. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require that you read and sign prior to any treatment. All patients must complete our information and insurance forms before seeing the doctor.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE. We accept cash, checks, Visa, MasterCard, Discover and American Express

We require that full payment of co-payments, deductibles, and any services not covered by your insurance plan be paid at the time the service is rendered. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance unless you bring in all insurance information at your initial visit. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your account in full within 45 days, the balance will be automatically transferred to your account. Please be aware some and possibly all of the services provided may be non-covered services, and not considered reasonable, usual, and customary under the terms of your dental policy.

Minor Patients

The adult accompanying a minor and/or the parents (or guardians) are responsible for full payment at the time of service. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, credit card, or payment by cash or check at time of service has been verified.

Missed Appointments

Unless canceled at least 48 hours in advance for an appointment with our hygienist and 72 hours in advance for an appointment with the doctor, our policy is to charge for missed appointments at the rate of $50.00 for the hygienist and $100.00 for the doctor. Please understand that missed appointment times are valuable to those patients that may find it hard to come to the doctor at other times. Please help us serve you better by keeping your scheduled appointments. Excessive cancellations and no shows will result in termination of our treatment agreement.

Collections

Any account that has not received payment in 60 days will be handed over to a collection agency that will pursue the responsible party for reimbursement. This will negatively impact your credit history and limit the treatment you can receive at our office.

Thank you for understanding our financial policy. Please let us know if you have any questions of concerns. We look forward to providing the highest quality dental care in a relaxing and caring atmosphere.

I have thoroughly read the Financial Policy. I understand and agree to this Financial Policy.

Patient Signature: _____ **Date:**_____

Downtown Periodontics and Implant Dentistry

Medical History

Patient Name:	Date of Birth:
Referring Dentist:	
Primary Physician Name:	Clinic Name:

Although dental personnel primary treat the area in and around your mouth, your mouth is a part of your 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 had a serious head or neck injury?	**YES**	**NO**	If yes, please explain:
Are you on a special diet?	**YES**	**NO**	If yes, please explain:
Do you use controlled substances?	**YES**	**NO**	If yes, please explain:
Are you a smoker?	**YES**	**NO**	If yes, how many/how often?

Have you received or are you currently receiving any of the following drugs:

Fosamax, Actonel, Boniva, Aredia or Zometa? **YES** **NO** If yes, please explain:

Do you require a Pre-Med?		**YES**	**NO**	If yes, please explain:
Women, are you **(check all that apply):**	Pregnant/Trying to get pregnant?		Nursing?	Taking Oral Contraceptives?

Are you allergic to any of the following (check all that apply)?

Acrylic	Local Anesthetics	Tetracycline	Aspirin
Metal	Codeine	Penicillin	Latex
Sulfa Drugs	Other:		**NO ALLERGIES**

Do you have, or have you had any of the following? Please **CIRCLE Y(yes) OR N(no)** if you have or had any of these conditions:

ADHD	Y N	Glaucoma	Y N	Rheumatism	Y N
AIDS/HIV	Y N	Hearing Loss	Y N	Shingles	Y N
Alzheimer's Disease	Y N	Heart Arrhythmia	Y N	Sinus Problems	Y N
Anemia- Chronic	Y N	Heart Attack/Congestive Heart Failure	Y N	Stomach Problems	Y N
Angina Pectoris	Y N	Heart Valve Replacement	Y N	Thyroid Disease	Y N
Anxiety Disorder	Y N	Hepatitis	Y N	Tuberculosis	Y N
Atrial Fibrillation	Y N	Herpes	Y N	Tumors	Y N
Arthritis	Y N	High Blood Pressure	Y N	Ulcers	Y N
Artificial Heart Valve	Y N	Kidney Disease	Y N		
Artificial Joint	Y N	Leukemia	Y N		
Asthma	Y N	Low Blood Pressure	Y N		
Autism	Y N	Lupus	Y N		
Cancer	Y N	Mental Illness	Y N		
Celiac Disease	Y N	Mitral Valve Prolapse	Y N		
Chemical/Alcohol/Drug Dependency	Y N	Multiple Sclerosis	Y N		
Coagulation Disorder	Y N	Organ Transplant	Y N		
Coumadin/Blood Thinners	Y N	Osteoporosis	Y N		
Crohn's Disease	Y N	Pacemaker	Y N		
Depression	Y N	Parkinson's Disease	Y N		
Diabetes	Y N	Pre-Medication	Y N		
Epilepsy or Seizures	Y N	Radiation/Chemotherapy	Y N		
Excessive Bleeding	Y N	Respiratory Problems	Y N		
Fibromyalgia	Y N	Rheumatic Fever	Y N		

Have you ever had a serious illness not listed above? **YES** **NO** If yes, please explain:_____

Please list your medications including vitamins and supplements:

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 the medical status.

Signature of Patient or Guardian:_____Date:_____