PATIENT REGISTRATION

Welcome! Please Complete the Following confidential information

Patient Information:

Name: _____
(First) (Middle) (Last)

DOB: _____ Sex: ☐ Male ☐ Female Marital Status: _____

Social Security #: _____ Email: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Employer: _____ Position: _____

Home Phone: _____ Work Phone: _____ Ext: _____

Mobile Phone: _____ ***Referred By***: _____

Primary Dental Insurance:

Dental Insurance: _____ Member ID #: _____

Group #: _____ Group Name: _____ Subscriber DOB: _____

Subscriber Full Name: _____ Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Partner

Claims Address: _____

Dental Insurance Phone #: _____

Secondary Dental Insurance:

Dental Insurance: _____ Member ID #: _____

Group #: _____ Group Name: _____ Subscriber DOB: _____

Subscriber Full Name: _____ Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Partner

Claims Address: _____

Dental Insurance Phone #: _____

Medical : Insurance Name: _____ ID #: _____ Group #: _____

Subscriber Full Name: _____ Subscriber DOB: _____

Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Partner Insurance Phone #: _____

Claims Address: _____

Emergency Contact:

Name: _____ Phone: _____ Relationship: _____

Consent:

I hereby authorize Prince William Dental, LLC staff to take x-rays, photographs and any other diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I consent to the use of appropri-ate medication and therapy as deemed necessary. I understand that during treatment it may be necessary to change or add procedure because of conditions found during treatment not evident during initial evaluation.

I hereby authorize payment of the dental benefits, otherwise payable to me, directly to Prince William Dental, LLC. I agree to be responsible for all charges for dental services and materials not paid by my dental insurance.

I understand that it is my responsibility to contact Prince William Dental 24hrs prior to my appointment if I fail to contact Oak Tree Dental I understand that there is a **30.00 Cancelation Fee/No Show Fee that will be incurred to my account and must be paid at the following visit.**

I understand that Pre-Treatments Estimates presented to me by Prince William Dental, LLC staff are only estimates provided by guidelines set by my insurance. I understand that these estimates are subject to change as my claim is processed by my insurance. I understand that Prince William Dental, LLC verifies my dental insurance benefits as a courtesy as it is my responsibility to understand my contractual obligations set forth by my dental insurance.

By Signing below, ***I certify that I have read and fully understand, and agree to the above items.***

Patient/Parent/Guardian's Signature: _____ **Date:** _____

PRINCE WILLIAM DENTAL

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 is 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 _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____

Are you on a special diet? ◯ Yes ◯ No

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

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 ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

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

SIGNATURE OF PATIENT, PARENT, or GUARDIAN_____ DATE_____

SIGNATURE OF DENTIST _____ DATE_____

DENTAL HISTORY

Reason for today's visit _____ Date of last dental care _____

Former Dentist _____ Date of last Dental X-rays _____

Have you ever had an unpleasant Dental experience**?** **Y** ☐ N ☐

(If yes, please describe, we want to make sure it does not happen again)

_____

_____

Check (✓) if you have had problems with any of the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking/Popping jaw
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Loose teeth/ broken fillings
- ☐ Sores/ growths in mouth
- ☐ Sensitivity to hot/cold
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting

AUTHORIZATION AND RELEASE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and /or my dependent(s), have insurance coverage with _____

Name of Insurance Company (ies)

, and assign directly to Prince William Dental LLC., all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Prince William Dental LLC., may use my health care information and may disclose such information to the above-named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

_____ _____

Signature of Patient, Guardian or Personal Representative *Date*

_____ _____

Please print name of Patient, Guardian or Personal Representative *Relationship to Patient*

Payment is due in full at the time of treatment unless prior arrangements have been approved.

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

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please specify)