Patient Registration Form

(PLEASE FILL OUT COMPLETELY IN CLEAR PRINT)

Patient Information:

☐ Mr. ☐ Ms. ☐ Mrs. ☐ Dr. First Name: _____Last Name: _____

Gender: ☐ Male ☐ Female ☐ Non-Binary Relationship Status: ☐ Single ☐ Married ☐ Prefer not to state

Birthday: ___ /___ /_____ Age: _____ Drivers License #: _____ SSN: ____ - ____ - ____

Email: _____ Home Phone: (_____) _____ Mobile Phone: (_____) _____

Address: _____ Apt. # _____

City: _____ State: _____ Zip _____

Occupation: _____ ☐ Full-Time ☐ Part-Time ☐ Retired

Student Status: ☐ N/A ☐ Full-Time ☐ Part-Time School: _____

How did you hear about us? ☐ Dentist/Orthodontist ☐ Family/Friend ☐ Online Search ☐ Yelp ☐ Other: _____

Can we send you text messages with appointment reminders/updates? ☐ Yes ☐ No

Emergency Contact Information:

I hereby authorize New Teeth Now to release my information to the following person in the event of a medical health emergency.

Name: _____ Relation: _____ Phone: (_____) _____

Parent or Legal Guardian Responsible for Account (If patient is a minor and/or disabled):

First Name: _____ Last Name: _____ Relation: _____

Birthday: ___ /___ /_____ Age: _____ Drivers License #: _____ SSN: ____ - ____ - ____

Email: _____ Home Phone: (_____) _____ Mobile Phone: (_____) _____

Address (if different): _____ Apt. # _____

City: _____ State: _____ Zip _____

Insurance Information:

Please bring your dental and medical insurance card to your consultation appointment.

Primary Dental Insurance:

Insurance Company Name: _____ Patient ID # _____

Group Name: _____ Group #: _____

Subscriber Name: _____ Relation: ☐ Self ☐ Parent ☐ Guardian ☐ Significant other

Subscriber Date of Birth: ___ /___ /_____ Phone: (_____) _____

Billing Address: _____

City: _____ State: _____ Zip _____

Primary Medical Insurance:

Insurance Company Name: _____ Patient ID # _____

Group Name: _____ Group #: _____

Subscriber Name: _____ Relation: ☐ Self ☐ Parent ☐ Guardian ☐ Significant other

Subscriber Date of Birth: ___ /___ /_____ Phone: (_____) _____

Billing Address: _____

City: _____ State: _____ Zip _____

Dental History:

Dentist: _____ Orthodontist: _____

Referred By: ☐ Dentist ☐ Orthodontist ☐ Friend/Family ☐ Other: _____

Reason for today's visit: _____

1. Have you had treatment for your current issues before? ☐ No ☐ Yes
   *If yes, explain:*_____
2. Have you experienced any swelling, drainage, or foul taste in your mouth? ☐ No ☐ Yes
3. Do you have trouble getting numb at the dentist's office? ☐ No ☐ Yes
4. Do you have a removable appliance and/or denture? ☐ No ☐ Yes
5. Do you have any jaw problems (clicking, popping, locking)? ☐ No ☐ Yes
6. Do you have a dry mouth? ☐ No ☐ Yes
7. Do you have a sensitive gag reflex? ☐ No ☐ Yes
8. Have you ever experienced dental, head/neck, or facial trauma? ☐ No ☐ Yes
9. Do you need to take an antibiotics before dental procedures? ☐ No ☐ Yes

Medical History:

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 care that you will be receiving. Information provided is strictly confidential and will not be released without your permission. Thank you for answering the following questions.

Height: _____ ft. _____in. Weight: _____ lbs.

Current Physician: _____ Tel: (_____) _____ Last Visit: _____

Cardiologist: _____ Tel: (_____) _____ Last Visit: _____

1. Are you in good overall health? ☐ No ☐ Yes
2. Are you currently under the care of a physician? ☐ No ☐ Yes
   If yes, for what are you being treated? _____
3. Have you had any illness, operation, or been hospitalized in the past 5 years? ☐ No ☐ Yes
   If yes, explain: _____
4. Do you have a prostethic joint/implant? ☐ No ☐ Yes
   If yes, describe where: _____
5. Do you use any tobacco products? (including smoking, vaping, chewing) ☐ No ☐ Yes
   If you smoke, how many cigarettes per day? _____
6. Do you smoke and/or consume cannabis/marijuana products? ☐ No ☐ Yes
7. Do you drink alcohol? ☐ No ☐ Yes
   If yes, how much? ☐ *Socially* ☐ *Daily* ☐ *Multiple times per week*
8. Do you use any illicit recreational drugs? ☐ No ☐ Yes
9. Have you ever been prescribed Fosamax, Boniva, Xgeva, or other bisphosphonate medications? ☐ No ☐ Yes
   If yes, when was your last dose? _____ *For how long?* _____
10. Have you ever had radiation treatment to the head and/or neck? ☐ No ☐ Yes
11. Have you ever been prescribed Celebrex? ☐ No ☐ Yes
12. Are you currently, or in the past 2 years, taken Prednisone or other steroid medications? ☐ No ☐ Yes
13. Have you ever had general anesthesia or IV sedation? ☐ No ☐ Yes
14. Have you, or a family member, had any unusual or serious reactions to general anesthesia? ☐ No ☐ Yes
    If yes, explain: _____

Have you been diagnosed with any of the following conditions?:

	No	Yes		No	Yes		No	Yes
Cardiovascular Disease			Asthma			Diabetes Type I		
Heart failure			Pheumonia			Diabetes Type II		
Heart valve problems			COPD			Low blood sugar		
Mitral valve prolapse			Emphysema			Hyperthyroidism		
Heart murmur			Chronic bronchitis			Hypothyroidism		
High blood pressure			Chroinic cough			Hashimotos		
Low blood pressure			Tuberculosis			Cancer		
Chest pain/Angina			Sinus problems			Tumors or growths		
Coronary artery disease			Snoring			Kidney disease		
Heart attacks			Sleep apnea/CPAP			Are you on dialysis?		
Stroke			Lung collapse			Fibromyalgia		
Irregular heart beat			Pulmonary embolism			Chronic pain		
Atrial fibrillation (A-Fib)			Difficulty breathing			Anxiety		
Tachycardia (fast heartrate)			Other lung problems			Depression		
Bradycardia (slow heartrate)			Chronic fatigue			Bipolar disorder		
Cardiac pacemaker			High cholesterol			Other psychiatric		
Implanted defibbrilator (ICD)			Bleeding disorders			Parkinson's Disease		
Heart stent			Anemia			Dementia		
Heart bypass			Blood transfusion			Autism		
Heart transplant			Do you bruise easily?			Intellectual disability		
Other heart surgery			Hemophila			Arthritis/Osteoarthritis		
Rheumatic fever			Hepatitis (A, B, C, D, E)			Osteoporosis/Osteopenia		
Other heart conditions			Jaundice			Lupus		
Deep vein thrombosis			Hepatic Cirrhosis			Malignant hyperthermia		
Circulatory problems			Other liver problems			Hearing problems		
Seizures/Epilepsy			Gall bladder problems			Eye problems		
Fainting spells			Acid Reflux/GERD			Herpes		
Migraines/Headaches			Ulcers			HIV/AIDS		

Please list any medical conditions not listed above:

Medications: Please list any medications you are currently taking:

Medication	Dose	Frequency	Medication	Dose	Frequency

Preferred Pharmacy: _____ **Pharmacy Phone Number:** (_____) _____

Allergies: Are you allergic to any of the following?:

	No	Yes		No	Yes
Latex			Codeine or any other narcotics (ex. Vicodin, Percocet)		
Penicillin/Amoxicillin			Barbituates (ex. Sodium Pentothal)		
Other antibiotics			Benzodiadepines (ex. Valium, Xanax, Ativan, Halcion)		
Sulfa drugs			Local anesthetic (ex. Lidocaine, Novocaine)		
Aspirin			Metals (ex. nickel, copper, cobalt)		
Ibuprofen			Iodine		
Acetaminophen			Sulfites		
Eggs			Seasonal Allergies/Pollen		
Please list any allergies not listed above:					

Women Only:

Are you pregnant or thinking of getting pregnant? ☐ No ☐ Yes

If yes, what is your expected delivery date? ___ /___ /_____

Are you nursing/breast-feeding? ☐ No ☐ Yes

Are you taking oral birth control? ☐ No ☐ Yes

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in medical status. I will not hold my doctor, or any other member of their staff, responsible for any errors or omissions that I have made in the completion of this form. My signature below confirms that I have read and understand everything as it has been explained to me by the SD Oral, Facial, and Implant Surgery staff.

X_____ Date_____
Signature of patient (Parent or Guardian if Minor)

Fees & Payments:
Insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and other pay a percentage of the charge. As a courtesy to you we will check benefits with your insurance carrier and, based on the information we receive, will estimate your out of pocket expenses. In no way, however, should this estimate be considered a guarantee of payment. Actual benefits will be determined by your insurance company when your claims are reviewed and processed by the insurance claim specialists. We will give you a comprehensive treatment plan with your best interest in mind, regardless of whether dental insurance may or may not contribute. In the event we do accept assignment of benefits and your insurance company has not paid your account in full within 90 days, the balance will be transferred to your account. So that you do not have to sign an insurance form at each dental visit SD Oral, Facial, and Implant Surgery will maintain a "signature on file" for you.
It is your responsibility to pay any deductible amount, co-insurance, co-pays, estimated patient portion, or any other balance not paid by your insurance carrier. By signing this authorization, I fully understand and agree to the terms of this policy, and I authorized the office to contact me via the contacts listed on the registration form regarding insurance and billing inquiries.

X_____ Date_____
Signature of patient (Parent or Guardian if Minor)

I hereby authorize SD Oral, Facial, and Implant Surgery to release any information, including the diagnosis and the records of any treatment or examination rendered to my insurance provider. I request my insurance to make payment directly to the dentist or dental group otherwise payable to me.

X_____ Date_____
Signature of patient (Parent or Guardian if Minor)

Authorization:
I authorize my surgeon and his/her designated staff, to perform an oral and maxillofacial examination, for the purpose of diagnosis and treatment planning. I authorize the taking of all x-rays required as a necessary part of this examination. In case of an emergency, I consent to treatment for that emergency. I understand that my doctor will discuss alternative forms of treatment as well as their risks and benefits. I have the right to decline treatment plans based upon the evaluation to which I am consenting. I understand that I am responsible to visit a dentist for regular cleanings to maintain my dental health. I authorize the release of any information acquired in the course of my examination and treatment to my other doctors and/or insurance carriers.

X_____ Date_____
Signature of patient (Parent or Guardian if Minor)

Acknowledgment of Notice of Privacy Practices:
I hereby acknowledge that this office's Notice of Privacy Practices has been made available to me. The complete policy may be found on the SD Oral, Facial, and Implant Surgery website. I have been given the opportunity to ask questions that I may have regarding this notice.

X_____ Date_____
Signature of patient (Parent or Guardian if Minor)

Health Insurance Portability and Accountability Act (HIPAA) Release:
Unless you have given written authorization otherwise, we can only discuss matters pertaining to protected health information with you (the patient) – this includes payments and billing, appointment changes/cancellations/confirmations, treatment plans, and past treatment. Please list anyone you would like to have the ability to call our office regarding your treatment, appointments, and accounts below.
In accordance with the provisions of the HIPAA, I grant permission to SD Oral, Facial, and Implant Surgery to disclose protected healthcare information (as defined by HIPAA) to the following persons:

Name _____ Relation _____ Contact _____

X_____ Date_____
Signature of patient

Office Policy Form

Thank you for choosing our office as your oral surgery care provider. Our doctors and team are committed to providing you with the best possible care. Please understand that payment is considered part of your treatment. Before seeing the doctor, you are required to complete the Registration, Office Policy, and HIPPA Acknowledgment forms.

Regarding Payment:
Payment for services is due at the time services are rendered unless prior arrangements have been made with our office.
We accept the following forms of payment: ***Cash, Check, Visa, MasterCard, American Express, Discover, CareCredit, and Lending Club.***
The parent/guardian who accompanies a minor child/children to their appointment is responsible for any payments due.

Regarding Insurance:
We will gladly assist you in whatever way possible to receive the maximum benefits available in your plan for treatment you may incur in our office. However, please be advised that the contract is between you, your employer, and your insurance company. We are not a party to that contract. We will give you a comprehensive treatment plan with your best interest in mind, regardless of whether dental insurance may or may not contribute.
As a courtesy to you, we will check benefits with your insurance carrier, and based on the information we receive, will estimate you're out of pocket expenses. However, in no way should this estimate be considered a guarantee of payment. Actual benefits will be determined by your insurance company when your claims are reviewed & processed by the insurance claim specialists. In the event we do accept assignment of benefits and your insurance company has not paid your account in full within 90 days, the balance will be transferred to your account. So that you do not have to sign a insurance form at each dental visit SD Oral, Facial, and Implant Surgery will maintain a "signature on file" for you. I hereby authorize SD Oral, Facial, and Implant Surgery to release any information including the diagnosis and the records of any treatment or examination rendered to my insurance provider. I request my insurance to make payment directly to the dentist or dental group otherwise payable to me. It is your responsibility to pay any deductible amount, coinsurance, co-pays, estimated patient portion, or any other balance not paid by your insurance carrier.
Your complete insurance information must be presented at the time services are provided. All insurance co-pays and deductibles must be paid at the time of service. Balances older than 120 days may be subject to collection and interest charges may apply. Returned checks will have an additional fee of $50.00 added to the amount of the returned check.

Sedation Policy:
If you are having IV general anesthesia, IV sedation, or oral sedation you are required to bring a responsible adult driver (18 years of age or older) to escort you to and from your appointment. If your ride is not present in the lobby when the surgery is finished you will be subject to an additional fee of $250 every 15 minutes your driver is not present. We encourage your ride to stay in the lobby for the duration of your surgery. If your ride will not be present during your appointment you will be required to sign the "Absent Ride Form" and provide payment information. If you are under 18 years of age you are required to have an adult legal guardian present in the lobby for the duration of your surgery. Our office cannot release a sedated (impaired) patient to any taxi or rideshare companies including but not limited to Uber, Lyft, and Yellow Cab.

Schedule / Reschedule / Cancellation Policy:
Our office has a 24 hour cancellation/reschedule policy prior to the date and time your appointment is scheduled. Please call the office as soon as possible if you have to reschedule. Please note that you may be charged $100.00 for cancellation/rescheduling appointments after the 24 hour deadline. Additionally, please note that you may be charged a no-show fee for missed appointments at the rate of $100.00.
Tardiness of 15 minutes or more is subject for the appointment to be rescheduled.
Certain treatments require a refundable deposit prior to scheduling a date for surgery. The deposit will be applied toward your out of pocket expense, if applicable. If there is no out of pocket cost for the treatment, the deposit will be refunded on the day of the surgery. The deposit becomes non-refundable 2-14 days prior to the date and time of surgery based on the treatment. Refer to your treatment plan for details.

CT Scan Waiver:
Your surgeon will interpret your CBCT scan solely for the purpose of evaluating your upper and lower jaws for your proposed treatment plan. The CBCT scan will not be read for the diagnosis of any other medical conditions. You may choose to have the obtained scan interpreted by a physician or licensed radiologist at your expense. A digital copy of your CBCT scan may be provided to you for an additional fee up to $295.

Contact:
By signing this policy you authorize the office to contact you via the contact information listed on the registration form regarding appointment, treatment, billing and/or insurance inquiries. Modalities of contact include but are not limited to phone call, text message, and email.

By signing below I have read, understand, and agree to this Office Policy.

X_____ Date_____
Signature of patient (Parent or Guardian if Minor)