Davis Family Dental, LLC

PATIENT REGISTRATION

Patient full name _____ Date _____

Email address _____ Home Phone: _____

Mailing Address _____ Business Phone: _____

City/State/Zip _____ Cell Phone: _____

Gender: M F Single ___ Married ____ Other ____ Date of Birth _____

Social Security Number _____

Employer's Name _____ Occupation _____

Spouse _____ SS # _____

Spouse's Employer Name _____ Occupation _____

Emergency Contact: Name: _____ Phone: _____

Relationship: _____

Address: _____

How did you hear about our office? Radio Newspaper Family/Friend Other_____
(Please circle one)

Who may we thank for your referral? _____

The best times for appointments for me are at: _____ (am/pm) Day of the week: M T W Th

How do you prefer to be reminded of your appointment? Email Text Telephone No preference
(Please circle)

DENTAL INSURANCE INFORMATION

Do you have dental insurance (Please circle)? Yes No

Primary Ins: Insurance Co. _____ Subscriber DOB: _____
Subscriber: _____ Subscriber Employer: _____
Subscriber SS#: _____ Do you have Secondary Ins? Yes No

METHOD OF PAYMENT / FINANCIAL POLICY / CANCELLATION-DISMISSAL POLICY

Thank you for choosing Davis Family Dental, LLC. Taking care of you and your family is our highest priority. An important part of that priority is making the cost of optimal care as easy and manageable as possible. Please note below our method of payment options available to use to pay for your dental treatment.

- Cash or Check: 5% discount for treatment paid in full prior to completion
- Credit or Debit Card: Visa or MasterCard
- Monthly payment plan: Short/Long Term financing available through CareCredit

1. **All fees are payable at the time of service.** I understand that insurance is provided as a service to me as a patient of Davis Family Dental, LLC, and that I am ultimately responsible for payment of service rendered, including any and all collection fees incurred.
2. I authorize my insurance carrier to issue the dental benefits to my plan directly to this dental office and authorize the release of any information necessary to process dental insurance.
3. I understand that insurance coverage is an ESTIMATE only and that my insurance is a contract between me and my insurance company and/or employer.
4. A finance charge of 1.5% per month may be assessed to accounts with balances outstanding for 60 days from treatment date. This finance charge represents an APR of 18%.
5. I understand that due to the high patient volume, it is your policy that upon **3 missed or failed appointments**, you reserve the right to discontinue treatment to me as a patient.

Patient Signature: _____**Date:** _____
(Parent or Legal Guardian)

PATIENT MEDICAL/DENTAL HISTORY

PATIENT NAME_____**DATE**_____

Medical Physician name: _____ Phone #: _____

Date of last medical exam: _____

1. Are you currently under medical treatment now? ..... Yes No

   If yes, what condition is being treated: _____

2. Have you had a serious illness, operation or hospitalized in the past 2 years? ..... Yes No

   If yes, please explain: _____

3. Have you had an orthopedic total joint replacement (hip, knee, elbow, shoulder, etc.)?..... Yes No

   If yes, what joint and when? _____ Any complications? _____

4. Are you taking or have you recently taken any prescription and/or over the counter medication? ..... Yes No

   If so, please list all medications, including vitamins, natural or herbal preparations and/or

   diet supplements: _____

   _____

5. Are you taking or scheduled to begin taking any of the following bisphosphonate medications?
   Fosamax, **Actonel**, **Aredia** or **Zometa**? ..... Yes No

   If so, when did the treatment begin? _____ When did the treatment end? _____

6. Have you ever been diagnosed with "high blood pressure?"..... Yes No

   Blood Pressure today: _____

7. Do you have a history of drug abuse? ..... Yes No

8. Do you smoke? ..... Yes No 9. Do you use chewing tobacco? ..... Yes No

9. **WOMEN:** Are you: Pregnant? .....Yes No If yes, # of weeks: _____ Due date: _____
   Taking birth control pills or hormonal replacement? ..... Yes No
   Nursing? ..... Yes No

10. Are you experiencing any dental pain or discomfort at this time?..... Yes No

11. Does having dental treatment make you nervous?.....Yes No

    Have you had a bad experience at a dental office?..... Yes No

12. Have you had problems associated with previous dental treatment?.....Yes No

13. Do your gums bleed easily when brushing?.....Yes No

14. Are your teeth sensitive to cold, hot, sweets or pressure?.....Yes No

15. Have you every had: orthodontics (braces).....Yes No
    periodontal (gum) treatments.....Yes No
    sores or ulcers in your mouth..... Yes No

16. Do you wear dentures and/or partials?.....Yes No If yes, for how long? _____

    Date of last dental exam: _____ Date of last dental x-rays: _____

17. What is the reason for your dental visit today? _____

18. Are you **allergic** to or have you had any reactions to the following:

Local Anesthetic	Yes	No	Sulfa drugs	Yes	No
Aspirin	Yes	No	Codeine or other narcotics	Yes	No
Penicillin	Yes	No	Any metals (nickel, mercury, etc.)	Yes	No
Latex (rubber)	Yes	No	Iodine	Yes	No
Barbiturates, sedatives, or sleeping pills	Yes	No	Other _____		
Hay fever/seasonal	Yes	No			

19. Do you have or have you had any of the following?

Artificial (prosthetic) heart valve……..	Yes	No	Cancer/Chemo/Radiation Therapy……..	Yes	No
Previous infective endocarditis……..	Yes	No	Chest pains upon exertion……	Yes	No
Damaged valves in transplanted heart……..	Yes	No	Diabetes Type I or II (please circle)……	Yes	No
Congenital heart disease (CHD)			GE reflux / persistent heartburn……	Yes	No
Unrepaired, cyanotic CHD……	Yes	No	Ulcers……	Yes	No
Repaired (completely) in last 6 months ..	Yes	No	Thyroid problems……	Yes	No
Repaired CHD with residual defects……	Yes	No	Stroke……	Yes	No
Tuberculosis……	Yes	No	Glaucoma……	Yes	No
Heart Disease……	Yes	No	Hepatitis, jaundice or liver disease……..	Yes	No
Angina……..	Yes	No	Epilepsy……Yes		No
Congestive heart failure……	Yes	No	Fainting Spells or seizures……	Yes	No
Damaged heart valves……Yes		No	Neurological disorders……Yes		No
Heart Attack……..Yes		No	If yes, specify: _____		
Heart Murmur……..	Yes	No	Mental health disorder……	Yes	No
Low Blood Pressure……Yes		No	If yes, specify: _____		
High Blood Pressure……..	Yes	No	Sleep disorder……	Yes	No
Mitral Valve Prolapse……	Yes	No	Kidney Disease……Yes		No
Pacemaker……...Yes		No	Osteoporosis……Yes		No
Rheumatic Fever……Yes		No	Severe headaches / migraines……	Yes	No
Rheumatic heart disease……...Yes		No	Severe or rapid weight loss……...Yes		No
Anemia……..Yes		No	Arthritis……..Yes		No
Hemophilia……...	Yes	No	Rheumatoid arthritis……Yes		No
AIDS or HIV infection……	Yes	No	Systemic lupus erythematosus……Yes		No
Sexually transmitted disease……	Yes	No	Asthma……	Yes	No
Sinus Trouble……..	Yes	No	Emphysema……	Yes	No

20. Do you have any disease, condition, or problem not listed above that you think I should know about?.....Yes No

If yes, please explain: _____

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. 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 medical status

Signature of Patient: _____ Date _____
(Parent or Legal Guardian)

Doctor's Use Only:

Comments on patient interview concerning medical history: _____

_____

Significant findings from questionnaire or oral interview: _____

_____

Dental management considerations: _____

_____

DENTAL/SKELETAL CLASSIFICATION: Class 1 ___ Class II: ___ Div I ___ Class III: ___
Div II ___

Davis Family Dental, LLC

PATIENT SMILE SURVEY

Is there anything about your smile that you do not like? _____

Are all of your teeth in alignment (straight)?.....Yes No Do you like the appearance of your teeth?.....Yes No
Do you have any missing teeth?.....Yes No Do you have any chipped teeth?.....Yes No

Is your bite comfortable when chewing and/or biting? _____

Do you have any old fillings or dental treatment that you are unhappy with? _____

Would you like to learn more about how you can improve your smile? ……. ……Yes No

If you could change anything about your smile, what would it be? (If you had a magic wand!) _____

_____

Is there anything that would keep you from improving your smile? _____

TMJ-Occlusion Questionnaire

Have you ever had or been diagnosed with a problem with either jaw joint?.....Yes No
Does your jaw joint click, pop or make noise when you open and close?.....Yes No
Do you have pain or tenderness in your jaw joint when you open, close or chew?.....Yes No
Has your jaw ever locked open or closed?.....Yes No
Do you have frequent headaches?.....Yes No If so, how often? _____
Do you clench or grind your teeth, or ever been told you do so?.....Yes No
Do you have a history or trauma to your chin or jaw?.....Yes No

TMJ ROM tests: Opening_____ mm Protrusive____ mm Lateral: L ____ mm R ____ mm

CONSENT FOR TREATMENT

1. I hereby authorize Dr. Davis or designated staff to take x-rays, study models, photographs and/or any other diagnostic aids deemed appropriate to make a thorough diagnosis of _____'s dental needs.
(name of patient)

2. Upon such diagnosis, I authorize Dr. Davis to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1.5% finance charge (18% APR) may be added to my account.

4. I agree that photos are a part of my dental record. Photos taken by Davis Family Dental, LLC may be used for case presentations as well as continuing education. Before/After photos may be used to present future case studies to patients, used on your dental web site, as well as in your office slide show. I hereby give you permission to use the following type of photos:
Teeth_____ Face_____

Thank you for your time and cooperation. We look forward to taking care of you!

Patient Signature: _____ **Date:** _____
(Parent or Legal Guardian)