Avalon Dental Care
Patient Registration Form

Patient Information

First Name:_____Last Name:_____M.I._____ Sex:_____Male _____Female
SSN:_____Drivers Lic:_____ Birth Date:_____Age:_____
Address:_____City, State, Zip:_____
Marital Status:____Married ____Single ____Divorced ____Separated ____Widowed

Contact information

Home Phone:_____Cell Phone: _____Work Phone:_____ext._____
Email:_____
Employer Name:_____ Occupation:_____
Address:_____City, State, Zip:_____

Emergency Contact

Name:_____Phone#:_____Relationship:_____

How did you hear about our office?_____

Responsible Party Information

Who is Responsible for this account?

First Name:_____Last Name_____M.I._____
SSN:_____ Driver License:_____Birth Date:_____
Address:_____City, State, Zip:_____
Relationship to Patient:_____
Home Phone:_____Cell Phone:_____Work
Phone:_____ext__

Insurance Information

Primary Insurance Information

Ins. Company:_____Address:_____City, State, Zip_____
Name of Insured:_____SSN/Insurance ID#:_____
Insured Birth Date:_____Relationship to Patient:_____
Employer Name:_____ Group#_____
Address:_____City, State, Zip_____

Secondary Insurance Information

Ins. Company:_____Address:_____City, State, Zip_____
Name of Insured:_____SSN/Insurance ID#:_____
Insured Birth Date:_____Relationship to Patient:_____
Employer Name:_____ Group#_____
Address:_____City, State, Zip_____

Avalon Dental Care is happy to bill your insurance company for you and will accept direct payment. Any patient balance may be paid by Visa, MasterCard, or check. Please keep in mind you are responsible for your total obligation should your insurance benefits result in less coverage than anticipated. **Your estimated portion of the charges is due at the time of service.** Please provide a 48hr notice for any cancellations. I certify that all information is true and correct to the best of my knowledge. I will notify you of any changes for the above information.

_____	_____	_____
Patient Name	**Patient Signature**	**Date**
_____	_____	_____
Parent/Guardian Name (if minor)	**Parent/Guardian Signature**	**Date**

Avalon Dental Care

ACKNOWLEDGEMENT OF RECEIPT OF AVALON DENTAL CARE'S NOTICE OF PRIVACY PRACTICE

By signing this document, I acknowledge that I have received a copy of Avalon Dental Care's Joint Notice of Privacy Practices.

_____	_____	_____
Name (print)	Signature	Date

FOR AVALON DENTAL CARE'S 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 _____ Communications barriers prohibited obtaining the acknowledgement _____ An emergency situation prevented us from obtaining acknowledgement _____ Other (please specify) _____ _____ _____

Avalon Dental Care

Financial Arrangement

In order to assist you in making payment for your dental treatment several options are available. Payment may be made with cash, check or credit card, unless specific arrangements have been made prior to treatment. Payment is due at the time services are rendered. We also offer financing through Care Credit for those who choose to give monthly payments over a period of time.

If you have dental insurance, we will bill your insurance carrier directly for you. Insurance plans vary and we will do our best to obtain information to help assist you in maximizing your benefits to the fullest. However, please remember that eligibility & benefits quoted by your insurance company are not a guarantee of payment. The percentage of coverage by your insurance company may be based by your employers own reduced fee schedule, which at times can only be provided by you. We have found that rarely does any insurance plan cover 100% of all services rendered. Insurance companies may not cover some routine and necessary dental services.

Your estimated portion of the charges is due at the time of service. Please keep in mind you are responsible for your total obligation should your insurance benefits result in less coverage than anticipated.

We reserve the right to charge a $25.00 fee for all checks returned for non-sufficient funds.

Any questions you may have concerning your treatment, financial arrangements or appointments please do not hesitate to ask.

Patient's Name:
Patient's Signature: Date:

Avalon Dental Care

DENTAL HISTORY

Patient: **Birth Date:**

Reason for Today's Visit:

Date of Last Dental Exam:
Date of Last Professional Cleaning:
Date of Last X-rays:

What would you like to discuss with the dentist today?

____Tooth Ache	**____Teeth Whitening**	**____Partial/Dentures**	**____Missing Teeth**
____Gum Problems	**____Cosmetics**	**____Braces/Invisalign**	**____Teeth Grinding**
____Bad Breathe	**____Crown/Bridge**	**____Wisdom Teeth**	**____Jaw Click/Pop**
____Sensitive Teeth			
____Second Opinion			

____Other_____
_____
_____

Is there anything you would like to change about your smile?
_____
_____
_____

MEDICAL HISTORY

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 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 _____

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 is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____