

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

Financial Arrangement

This agreement is to inform you of your financial obligation to our practice. We are committed to providing you with high quality dental care using only the best material and technology available today. This financial agreement is intended to facilitate our ability to provide excellent service to you while minimizing our administrative costs.

All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and the insurance company. Our office is not a party to that contract.

As a courtesy to you we will process all of your insurance claims. However, please remember that eligibility and quoted by your insurance company are not a guarantee of payment.

Your estimated co-payment for treatment, which is the amount not covered by your insurance, fee for all checks returned for non-sufficient funds. We strive to accommodate the scheduling needs of our patients, and we will make every effort to keep your scheduled appointment on time. Failure to provide us with 48 hours advance notice of failure to show up for scheduled appointment will result in a cancellation/no show fee of \$50. Any account balance over 30 days will be subject to a monthly billing charge of \$10.

In the event of any claim, controversy, or dispute, the essential nature of which involves personal injury, malpractice or any tort, by patient, his dependents, whether or not minors, heirs at law of personal representatives against Doctor, treating provider, or Avalon Dental Care, the sole methods for resolving such dispute shall be binding arbitration administered by the American Arbitration Association. Both parties are giving up their right to have such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

I understand that each dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I understand that no other dentist other than the treating dentist is responsible for my dental treatment.

Any question you may have, please do not hesitate to ask. We thank you for your cooperation and understanding.

Patient's Name:

Date:

Patient's Signature:



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?

<input type="checkbox"/> Tooth Ache	<input type="checkbox"/> Teeth Whitening	<input type="checkbox"/> Partial/Dentures	<input type="checkbox"/> Missing Teeth
<input type="checkbox"/> Gum Problems	<input type="checkbox"/> Cosmetics	<input type="checkbox"/> Braces/Invisalign	<input type="checkbox"/> Teeth Grinding
<input type="checkbox"/> Bad Breathe	<input type="checkbox"/> Crown/Bridge	<input type="checkbox"/> Wisdom Teeth	<input type="checkbox"/> Jaw Click/Pop
<input type="checkbox"/> Sensitive Teeth			
<input type="checkbox"/> Second Opinion			
<input type="checkbox"/> 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 <input type="radio"/> Yes <input type="radio"/> No | Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No | Hemophilia <input type="radio"/> Yes <input type="radio"/> No | Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No |
| Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No | Diabetes <input type="radio"/> Yes <input type="radio"/> No | Hepatitis A <input type="radio"/> Yes <input type="radio"/> No | Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No |
| Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No | Drug Addiction <input type="radio"/> Yes <input type="radio"/> No | Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No | Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No |
| Anemia <input type="radio"/> Yes <input type="radio"/> No | Easily Winded <input type="radio"/> Yes <input type="radio"/> No | Herpes <input type="radio"/> Yes <input type="radio"/> No | Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No |
| Angina <input type="radio"/> Yes <input type="radio"/> No | Emphysema <input type="radio"/> Yes <input type="radio"/> No | High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No | Rheumatism <input type="radio"/> Yes <input type="radio"/> No |
| Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No | Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No | High Cholesterol <input type="radio"/> Yes <input type="radio"/> No | Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No | Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No | Hives or Rash <input type="radio"/> Yes <input type="radio"/> No | Shingles <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Joint <input type="radio"/> Yes <input type="radio"/> No | Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No | Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No | Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No |
| Asthma <input type="radio"/> Yes <input type="radio"/> No | Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No | Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No | Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No |
| Blood Disease <input type="radio"/> Yes <input type="radio"/> No | Frequent Cough <input type="radio"/> Yes <input type="radio"/> No | Kidney Problems <input type="radio"/> Yes <input type="radio"/> No | Spina Bifida <input type="radio"/> Yes <input type="radio"/> No |
| Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No | Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No | Leukemia <input type="radio"/> Yes <input type="radio"/> No | Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No |
| Breathing Problem <input type="radio"/> Yes <input type="radio"/> No | Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No | Liver Disease <input type="radio"/> Yes <input type="radio"/> No | Stroke <input type="radio"/> Yes <input type="radio"/> No |
| Bruise Easily <input type="radio"/> Yes <input type="radio"/> No | Genital Herpes <input type="radio"/> Yes <input type="radio"/> No | Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No | Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No |
| Cancer <input type="radio"/> Yes <input type="radio"/> No | Glaucoma <input type="radio"/> Yes <input type="radio"/> No | Lung Disease <input type="radio"/> Yes <input type="radio"/> No | Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No |
| Chemotherapy <input type="radio"/> Yes <input type="radio"/> No | Hay Fever <input type="radio"/> Yes <input type="radio"/> No | Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No | Tonsillitis <input type="radio"/> Yes <input type="radio"/> No |
| Chest Pains <input type="radio"/> Yes <input type="radio"/> No | Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No | Osteoporosis <input type="radio"/> Yes <input type="radio"/> No | Tuberculosis <input type="radio"/> Yes <input type="radio"/> No |
| Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No | Heart Murmur <input type="radio"/> Yes <input type="radio"/> No | Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No | Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No |
| Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No | Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No | Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No | Ulcers <input type="radio"/> Yes <input type="radio"/> No |
| Convulsions <input type="radio"/> Yes <input type="radio"/> No | Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No | Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No | Venereal Disease <input type="radio"/> Yes <input type="radio"/> No |
| | | | Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> 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 _____