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

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 eligilitly 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:

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 _____