

PATIENT REGISTRATION

Patient Name (Last, First, Middle Initial)	Date of Birth	Social Security Number	Sex Male Female
			Marital Status Single Married
Address	City	State	Zip
Home Phone: Work Phone: Cell Phone:	How do you prefer to be addressed?		
E-Mail Address (print clearly)			
Employer	Occupation	Relationship to Insured SELF SPOUSE CHILD OTHER	

PRIMARY DENTAL INSURANCE CARRIER

SECONDARY DENTAL INSURANCE CARRIER

Insured Name		Insured Name	
Date of Birth		Date of Birth	
Social Security Number		Social Security Number	
Insurance Company	Group Number	Insurance Company	Group Number
Employer	Occupation	Employer	Occupation

WHO SHOULD BE NOTIFIED LOCALLY IN CASE OF EMERGENCY?

Name	Phone
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REFERRED TO THIS OFFICE BY:

Friend/Family Member: (so we can thank them) _____

Phone Book

Internet

Insurance List

Sign Out Front

Signature _____ Date _____

OFFICE NOTES

Patient Name

PATIENT MEDICAL HISTORY

Your comfort and good dental health are dependent upon an accurate knowledge of your medical well-being. Many medical situations can affect or be affected by procedures or drugs used for dentistry. Therefore, please fill out the following carefully. THANK YOU.

HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS? Please X If Yes

Latex Allergy	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	Emotional Concerns/Psychiatric Care	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	Fainting or Dizziness	<input type="checkbox"/>	Chronic Sinus Problems	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	Thyroid Condition	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	Bleeding or Blood Problem	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Herpes Simplex I (canker sores)	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	AIDS or AIDS Related Complex	<input type="checkbox"/>
Alcoholism	<input type="checkbox"/>	Stomach Ulcer	<input type="checkbox"/>	Malignancies or Tumors	<input type="checkbox"/>

- Have you experienced an unusual reaction to any of the following: **YES** **NO**
 Penicillin, Codeine, Aspirin or any other drug?.....
- Do you smoke? Packs per day ____.....
- Have you had any prosthetic surgery such as: artificial heart valve replacement
 or an artificial hip or joint replacement?.....
- Have you received or are you currently receiving medication known as
 bisphosphonates (for example, zoledronic acid [Zometa] or pamidronate [Aredia])?
- Are you under any medical treatment or taking medication now?.....
- Are you now or ever been treated with chemotherapy or radiation?.....

If you have marked any of the above with a yes, please give us a brief history:

Name of Physician: _____
Name of Specialist: _____

Phone: _____
Phone: _____

WOMEN

- Are you pregnant?..... **YES** **NO**
- Are you taking any birth control medication?.....

DENTAL HISTORY

Have you ever experienced an unusual reaction to dental anesthetics (Novocaine-Carbocaine?) _____

How long has it been since your last dental cleaning? _____

What were you last seen by a dentist for? _____

What did you like most about your previous dentist? _____

What did you like least? _____

What are you expecting today? _____

Would you like whiter teeth? _____

I hereby certify that the above information is true and correct

Signature _____ Date _____ Updated _____

FINANCIAL POLICY FOR DES MOINES DENTAL CENTER

It is our optimal goal to provide you and your family with the highest quality of dental care while maintaining a friendly and relaxing environment. In order to keep our standard of care at a level which best serves your dental needs, we ask you to please observe the following guidelines:

OUR FINANCIAL POLICY:

Payment is due at time of treatment. For your convenience, we offer several payment options: WE ACCEPT CASH, CHECKS (NSF Fee \$75.), or VISA/MASTERCARD, DISCOVER, AMERICAN EXPRESS. WE OFFER EXTENDED PAYMENT PLAN WITH PRIOR CREDIT APPROVAL(Care Credit).

REGARDING INSURANCE:

We accept assignment of insurance benefits, however we do require your co-payment and deductibles to be paid at the time of service. The balance is your responsibility whether your insurance company pays or not. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your account in full within 60 days, the entire balance will be payable by you. All accounts over 90 days will be subject to a finance charge of 1.0% per month, which is an annual rate of 12%.

USUAL AND CUSTOMARY RATES:

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of your insurance company's arbitrary determination of usual and customary rates.

MEDIA USAGE:

I hereby permit Des Moines Dental Center to use any and all media forms including, but not limited to, photographs, copy, and xrays for use on the Des Moines Dental Center web site.

CANCELLATION POLICY:

There are many times when our patients require urgent or emergency treatment and therefore need an appointment as soon as possible. When patients give the office advance notice of their need to cancel a scheduled appointment, this time can then be allocated to those patients with immediate needs. In this way the office can best serve the needs of ALL patients. Bearing this in mind, our office requires a minimum of 24 hours notice if an appointment must be cancelled. If less than 24 hours notice has been given to cancel an appointment, a \$50 fee will be assessed.

An adult must accompany all minors during the entire length of minor's appointment.

(Some exceptions may be allowed after authorization form is signed by parent / legal guardian.)

We at the Des Moines Dental Center look forward to taking care of your oral health needs and welcome you and your family to our team of dental professionals.

I have read the above policies of the Des Moines Dental Center and understand my responsibilities as a patient.

Patient Signature _____ Date _____