

PATIENT REGISTRATION

Patient Information

First Name: _____ Last Name: _____

Preferred Name (If different than above): _____

Address: _____

City: _____ State / Zip Code: _____ / _____

Birth Date: ____/____/____ Social Security Number: _____ Sex: ☐ Male ☐ Female

Cell Phone: (____) _____ Home Phone: (____) _____
(Text messages will be sent to confirm appointments- opt out options are available)

Email: _____ Work Phone: (____) _____
(E-mail messages will be sent to confirm appointments and/or office promotions- opt out options are available) Ext: _____

Preferred Pharmacy: _____

Emergency Contact: _____ Relationship: _____ Phone: (____) _____

Patient History

Last Dental Visit: _____ Previous Dentist: _____

How did you hear about our office? If you were referred by one of our patients, please write their name so we can thank them. _____

Responsible Party (If patient is under 18 years old)

First Name: _____ Last Name: _____

Address: _____

City: _____ State / Zip Code: _____ / _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Birth Date: ____/____/____ Social Security Number: _____ Ext: _____

PATIENT DISCLOSURE INFORMATION

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. The individual's health information will be made available to referred specialists for the individual's advised treatment.

I allow you to give my clinical information to and answer questions from (check all that apply):

PLEASE LIST NAME AND PHONE NUMBER

☐ Spouse: _____

☐ Parent(s): _____

☐ Other (specify): _____

☐ None

Patient (or Guardian) Signature

____/____/____
Date

Print Name

24 Hour Cancellation Policy /Understanding Your Dental Benefits

We value your time and reserve appointment times based on the needs of each patient. By providing us with enough notice for rescheduling your appointment, we are able to open the reserved time up to other patients needing to be seen. This policy makes scheduling convenient for patients and allows us to begin and end your appointments on time.

We kindly ask that you provide a 24-hour notice if you must cancel an appointment. Without a 24-hour notice (also known as a broken appointment), there will be a **\$50.00 charge** added to your account for any missed or broken appointments. This will not be covered by your insurance company and must be paid prior to rescheduling an appointment. Three broken appointments may result in dismissal from the practice.

Dental benefits have become an integral part of health care planning for many families. As the number of patients covered by dental plans has increased, certain assumptions have become evident. I would like to make the principles of my practice, as well as the types of service and care I provide my patients, very clear:

- Our fees are based on the overhead involved in the practice, the treatment plan selected, and the time it takes to provide you with the necessary dental care.
- The type of treatment you need and receive is based on my professional judgment and not on whether you are covered by a dental benefits plan. I am more than happy to discuss a treatment plan's advantages and disadvantages with you in order to accommodate you, not an insurance company, in the health care decision-making process.
- If treatment is recommended, our office will complete and present a treatment plan to you showing what treatment is recommended, the order in which the treatment is recommended to be rendered, the fees our office charges for the services needed, and an estimation of what your dental plan may cover.
This is only an estimation of your dental benefits.
- The amount estimated to be your "out of pocket" on the treatment plan will be **due when services are rendered.**
- As a courtesy to you, our office will complete the dental claim form and send it to your insurance company.
- Your dental plan holds the right to deny or pay a different fee amount for services rendered. This may result in a further payment due to our office. **This balance is YOUR responsibility.**
- Pre-authorizations can be sent for the insurance company to review. However, please remember that the financial obligation for dental treatment is yours.

No question is too small for you to ask, whether it is about your treatment, benefit plan, or statement. Stop in or call us at (937) 738-7610 any time you have a question. We are here to help you and provide you with the best dental care possible!

By initialing below, I agree that I have read and understand the above information. I have been given a chance to ask any questions regarding my individual insurance policy. I understand that the policy may be changed at any time without notice. _____ (Initial)

By signing below, I agree that any balance due after insurance payment is my responsibility and not that of Cromwell Dental Care.

Printed Name: _____

Signature: _____

Date: _____

Acknowledgement of Receipt of Notice of Privacy Practices

** You May Refuse to Sign This Acknowledgment**

I acknowledge that I have read a copy of the Notice of Privacy Practices from Cromwell Dental Care. I also acknowledge that I was given the option to receive a copy of the Notice of Privacy Practices for my own personal records.

Signature_____

Medical History**PATIENT NAME:** _____**Birth Date:** _____**Date:** _____**Medical History**

Who is your primary care physician? _____

Date of Last visit with primary care? _____

Have you ever taken medications containing bisphosphonates? ☐ Yes ☐ No If Yes: _____
 (EX: Actonel, Boniva, Fosamax)

Have you had a joint replacement/artificial joint? If yes, indicate ☐ Yes ☐ No If Yes: _____
 which joint(s) and date of surgeries:

Do you use any tobacco/vaping products? If yes, what product, ☐ Yes ☐ No If Yes: _____
 how much and for how long?

Do you have diabetes (type 1 or 2)? If yes, is it monitored ☐ Yes ☐ No If Yes: _____
 controlled with a physician? Last A1C?

Have you had a stroke or heart attack? If yes, please provide ☐ Yes ☐ No If Yes: _____
 dates of events:

Are you currently pregnant? If yes, what is your approximate ☐ Yes ☐ No If Yes: _____
 due date?

Have you had any surgeries or operations? ☐ Yes ☐ No If Yes: _____

Medical Conditions

Please mark any conditions you have been diagnosed with and/or medicated for:

- | | | | |
|---|--|---|---|
| ☐ Acid Reflux | ☐ Angina/Chest Pains | ☐ Arthritis/Gout | ☐ Artificial Heart Valve |
| ☐ Asthma | ☐ Blood Diseases | ☐ Cancer | ☐ Chemical Dependency |
| ☐ Chemotherapy | ☐ Cortisone Treatments | ☐ Cough (persistent) | ☐ Diabetes |
| ☐ Epilepsy/Seizures | ☐ Fainting | ☐ Glaucoma | ☐ Frequent Headaches |
| ☐ Heart Murmur | ☐ Heart Attack | ☐ Hemophilia | ☐ Hepatitis B |
| ☐ Hepatitis C | ☐ High Blood Pressure | ☐ HIV/AIDS | ☐ Jaw Pain |
| ☐ Kidney Disease | ☐ Liver Disease | ☐ Pacemaker | ☐ Radiation Treatment |
| ☐ Respiratory Disease | ☐ Shortness of Breath | ☐ Skin Rash | ☐ STI/STD |
| ☐ Stroke | ☐ Swelling of Feet/Ankles | ☐ Thyroid Problems | ☐ Tonsillitis |
| ☐ Tuberculosis (Current) | ☐ Ulcers | ☐ Other Autoimmune | ☐ Other Heart |
| ☐ Mental Health Conditions | ☐ Neurological Disorders | | |

Please put comments about medical conditions here (if applicable):**Please list any medications (including OTC and Vitamins). If you have a list, we can scan it into your chart:**

Allergies

Do you have any drug allergies? Please mark all that apply. **IF NO ALLERGIES PLEASE MARK NONE:**

☐ Penicillin ☐ Sulfa Drugs ☐ Aspirin ☐ Other NSAIDS
☐ Codeine ☐ Latex ☐ Local Anesthetics ☐ Other (please specify):
☐ **None**

Reason for Today's Visit:

What concerns bring you in today? _____

Who was your previous dentist? _____ Location? _____

Date of last dental exam/visit? _____

Date of last dental xrays? _____

Dental History

Do you have any missing teeth? If yes, would you like to discuss replacement? ☐ Yes ☐ No If Yes: _____

Have you ever been treated for periodontal disease? ☐ Yes ☐ No If Yes: _____

Do you currently wear any removable appliances? ☐ Yes ☐ No If Yes: _____
(dentures, partials)

Do you clench or grind your teeth? If yes, do you have or have you had a night guard? ☐ Yes ☐ No If Yes: _____

Do you have any other concerns about your teeth you would like to discuss today?

☐ Whitening ☐ Straightening your smile ☐ Athletic Guard/Night Guard
☐ Sleep Apnea ☐ Implants ☐ Cosmetic Dentistry
☐ Wisdom Teeth Removal

Please mark dental care items you are currently using:

☐ Electric Toothbrush ☐ Water Flosser ☐ Prescription Rinse/Toothpaste
☐ Manual Toothbrush ☐ Traditional Floss/Picks ☐ Sensitivity Toothpaste

How often are you brushing?

☐ Twice Daily ☐ Once Daily ☐ Few times a week
☐ Infrequently/As Needed ☐ Never

How often are you flossing? (Mark best option for your habit)

☐ Twice Daily ☐ Once Daily ☐ Few times a week
☐ Infrequently/As Needed ☐ Never

Signature of Patient, Parent or Guardian:

X _____ Date: _____