

GENERAL PATIENT INFORMATION

Patient Registration

Patient Information

Full Name: _____

Date of Birth: _____

Marital Status: Single Married Separated Divorced Widowed

Sex: Male Female

SSN/ID: _____

Email Address: _____

Home Phone Number: _____

Cell Phone Number: _____

Drivers License

State: _____

Number: _____

Home Address:

Address: _____

City, State and ZIP: _____

Billing Address:

Address: _____

City, State and ZIP: _____

Work Information

Employer: _____

Occupation: _____

Work Phone Number: _____

Method of Contact: Phone Email Text Message Any of the previous ones

Emergency Contact:

Full Name: _____

Phone Number: _____

Relation: _____

How did you hear about our office?

Who may we thank for referring you? _____

Signature: _____

GENERAL PATIENT INFORMATION

Financial Information

Patient's Payment Details – Guarantor (Person responsible for paying the bill)

Guarantor Name: _____
SSN/ID: _____
Relation to Patient: _____

Patient's Student Status

Student Status: _____
College: _____
College Address: _____

Primary Dental Insurance Company – Subscriber and Insurance Company Details

Subscriber Name: _____
Date of Birth: _____
SSN/ID: _____
Employer: _____
Policy Number: _____
Group Number: _____
Coverage Type: Individual Family Prepaid / Capitation
Insurance Company: _____
Company Phone Number: _____
Company City, State, ZIP: _____

Secondary Dental Insurance Company – Subscriber and Insurance Company Details

Subscriber Name: _____
Date of Birth: _____
SSN/ID: _____
Employer: _____
Policy Number: _____
Group Number: _____
Coverage Type: Individual Family Prepaid / Capitation
Insurance Company: _____
Company Phone Number: _____
Company City, State, ZIP: _____

Pharmacy Information

Name: _____
Address: _____
Pharmacy Phone Number: _____

Medicaid Number:

I authorize the dentist to release any information, including diagnosis, treatment plans/records and radiographs to third party payers and/or health practitioners. I authorize and request that my insurance company (if applicable) pay directly to the dental group or dentist benefits that are, otherwise, payable to me. I understand that my dental insurance may pay less than the actual bill for service or may not cover certain treatment.

I hereby certify that the foregoing information is accurate and complete and that in consideration of treatment and services rendered to me or my dependents by this dental office, I accept responsibility and agree to be obligated to pay the office in accordance with its payment and credit terms and policies.

Signature: _____

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? Excellent Good Fair Poor

DO YOU HAVE or HAVE YOU EVER HAD:

- | | YES | NO | | YES | NO |
|--|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 1. hospitalization for illness or injury _____ | <input type="checkbox"/> | <input type="checkbox"/> | 26. osteoporosis/osteopenia (i.e. taking bisphosphonates) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. an allergic reaction to | | | 27. arthritis _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> aspirin, ibuprofen, acetaminophen, codeine | | | 28. glaucoma _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> penicillin | | | 29. contact lenses _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> erythromycin | | | 30. head or neck injuries _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> tetracycline | | | 31. epilepsy, convulsions (seizures) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> sulpha | | | 32. neurologic problems (attention deficit disorder) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> local anesthetic | | | 33. viral infections and cold sores _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> fluoride | | | 34. any lumps or swelling in the mouth _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> metals (nickel, gold, silver, _____) | | | 35. hives, skin rash, hay fever _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> latex | | | 36. venereal disease _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> other _____ | | | 37. hepatitis (type _____) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. heart problems, or cardiac stent within the last six months _____ | <input type="checkbox"/> | <input type="checkbox"/> | 38. HIV / AIDS _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. history of infective endocarditis _____ | <input type="checkbox"/> | <input type="checkbox"/> | 39. tumor, abnormal growth _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. artificial heart valve, repaired heart defect (PFO) _____ | <input type="checkbox"/> | <input type="checkbox"/> | 40. radiation therapy _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. pacemaker or implantable defibrillator _____ | <input type="checkbox"/> | <input type="checkbox"/> | 41. chemotherapy _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. artificial prosthesis (heart valve or joints) _____ | <input type="checkbox"/> | <input type="checkbox"/> | 42. emotional problems _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. rheumatic or scarlet fever _____ | <input type="checkbox"/> | <input type="checkbox"/> | 43. psychiatric treatment _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. high or low blood pressure _____ | <input type="checkbox"/> | <input type="checkbox"/> | 44. antidepressant medication _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. a stroke (taking blood thinners) _____ | <input type="checkbox"/> | <input type="checkbox"/> | 45. alcohol / drug dependency _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. anemia or other blood disorder _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 12. prolonged bleeding due to a slight cut (INR > 3.5) _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 13. emphysema, sarcoidosis _____ | <input type="checkbox"/> | <input type="checkbox"/> | ARE YOU: | | |
| 14. tuberculosis _____ | <input type="checkbox"/> | <input type="checkbox"/> | 46. presently being treated for any other illness _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. asthma _____ | <input type="checkbox"/> | <input type="checkbox"/> | 47. aware of a change in your general health _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. breathing or sleep problems (i.e. snoring, sinus) _____ | <input type="checkbox"/> | <input type="checkbox"/> | 48. taking medication for weight management (i.e. fen-phen) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. kidney disease _____ | <input type="checkbox"/> | <input type="checkbox"/> | 49. taking dietary supplements _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. liver disease _____ | <input type="checkbox"/> | <input type="checkbox"/> | 50. often exhausted or fatigued _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. jaundice _____ | <input type="checkbox"/> | <input type="checkbox"/> | 51. subject to frequent headaches _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. thyroid, parathyroid disease, or calcium deficiency _____ | <input type="checkbox"/> | <input type="checkbox"/> | 52. a smoker or smoked previously _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. hormone deficiency _____ | <input type="checkbox"/> | <input type="checkbox"/> | 53. considered a touchy person _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. high cholesterol or taking statin drugs _____ | <input type="checkbox"/> | <input type="checkbox"/> | 54. often unhappy or depressed _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. diabetes (HbA1c = _____) _____ | <input type="checkbox"/> | <input type="checkbox"/> | 55. FEMALE - taking birth control pills _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. stomach or duodenal ulcer _____ | <input type="checkbox"/> | <input type="checkbox"/> | 56. FEMALE - pregnant _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. digestive disorders (i.e. gastric reflux) _____ | <input type="checkbox"/> | <input type="checkbox"/> | 57. MALE - prostate disorders _____ | <input type="checkbox"/> | <input type="checkbox"/> |

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

List all medications, supplements, and or vitamins taken within the last two years

Drug	Purpose	Drug	Purpose

Ask for an additional sheet if you are taking more than 6 medications

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____



DENTAL HISTORY

Referred by _____ How would you rate the condition of your mouth? Excellent Good Fair Poor

Previous Dentist _____ How long have you been a patient? _____ Months/Years

Date of most recent dental exam ____/____/____ Date of most recent x-rays ____/____/____

Date of most recent treatment (other than a cleaning) ____/____/____

I routinely see my dentist every: 3 mo. 4 mo. 6 mo. 12 mo. Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

YES NO

PERSONAL HISTORY

1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [] _____ YES NO
2. Have you had an unfavorable dental experience? _____ YES NO
3. Have you ever had complications from past dental treatment? _____ YES NO
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____ YES NO
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____ YES NO
6. Have you had any teeth removed? _____ YES NO

SMILE CHARACTERISTICS

7. Is there anything about the appearance of your teeth that you would like to change? _____ YES NO
8. Have you ever whitened (bleached) your teeth? _____ YES NO
9. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____ YES NO
10. Have you been disappointed with the appearance of previous dental work? _____ YES NO

BITE AND JAW JOINT

11. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____ YES NO
12. Do you / would you have any problems chewing gum? _____ YES NO
13. Do you / would you have any problems chewing bagels, baguettes, protein bars, or other hard foods? _____ YES NO
14. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____ YES NO
15. Are your teeth crowding or developing spaces? _____ YES NO
16. Do you have more than one bite and squeeze to make your teeth fit together? _____ YES NO
17. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____ YES NO
18. Do you clench your teeth in the daytime or make them sore? _____ YES NO
19. Do you have any problems with sleep or wake up with an awareness of your teeth? _____ YES NO
20. Do you wear or have you ever worn a bite appliance? _____ YES NO

TOOTH STRUCTURE

21. Have you had any cavities within the past 3 years? _____ YES NO
22. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____ YES NO
23. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____ YES NO
24. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? _____ YES NO
25. Do you have grooves or notches on your teeth near the gum line? _____ YES NO
26. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____ YES NO
27. Do you get food caught between any teeth? _____ YES NO

GUM AND BONE

28. Do your gums bleed when brushing or flossing? _____ YES NO
29. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____ YES NO
30. Have you ever noticed an unpleasant taste or odor in your mouth? _____ YES NO
31. Is there anyone with a history of periodontal disease in your family? _____ YES NO
32. Have you ever experienced gum recession? _____ YES NO
33. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____ YES NO
34. Have you experienced a burning sensation in your mouth? _____ YES NO

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Denti Belli Dentistry

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Missed Appointment and Financial Policy

*Please note that our time is valuable and so is yours. We require a minimum of two office days notice (Monday through Thursday) for any cancelled appointments, otherwise a missed appointment fee will be charged to your account. Our confirmation system is as follows: email reminders are sent 2 weeks prior to the appointment, phone calls are made 1 week and 1 day prior to appointment (until the appointment is actually confirmed). Due to the nature of our practice, we require a minimum of 48 business hours for all other cancellations to be considered a non-charged transaction.

Best email address for confirmation: _____

Best phone number for confirmation: _____

Type of Appointment

Broken Appointment Fee

Hygiene Appointment

\$50/hour

Doctor Appointment

\$75.00/hour

Insurance

As a courtesy to our patients, we will bill your insurance company on your behalf. We do however, require the patient's portion to be paid in full at the time of service. *The balance is your responsibility whether your insurance company pays or not.* We cannot bill your insurance company unless you provide correct insurance information with an insurance billing address and telephone number. In some instances an original claim form may be required. Your insurance is a contract between you and your insurance company. We are not a party to that contract. **If for any reason your insurance company denies any charges, the responsibility for payment or resubmission returns to you.** If there is dental insurance, we will assist in maximizing your dental insurance benefits including filling out and filing forms at no additional charge. It is the patient's responsibility to communicate with their insurance company and their employer regarding premium coverage. **It is our responsibility to make recommendations for what we feel is the best treatment for our patients – NOT letting the insurance companies dictate treatment recommendations based on your insurance limitations.** Many patients think dental insurance "covers everything." In reality, few policies do. We will do our best to make as close of a calculation as possible of what the insurance plan will pay allowing our patients to know in advance what will be expected of them at the time of the appointment.

Minor Patients

For unaccompanied minors, non-emergency treatment will be denied unless treatment and payment have been pre-approved. The adult accompanying the minor, or parent, is responsible for payment.

I have read, understand and agree to comply with the above stated office policies.

Signature: _____

Date: _____

NO INSURANCE? NO PROBLEM!

Take advantage of Denti Belli Dentistry In House Membership Savings Plan

The best deal we have to offer is our in house membership savings plan. This plan covers one, two or the entire family! It includes everything you will need and is good for one year from date of purchase. It is dentistry made easy. No more worrying about copays, deductibles or unexpected out of pocket expenses. Our in house membership plan is a dental savings plan that makes quality dentistry more affordable for individuals and families. Best of all, there is no waiting period. You will qualify for immediate treatment with no benefit limitations. One low annual fee covers everyone in the family for an entire year!

When you join our In House Membership Savings Plan, you get access to valuable savings on annual exams, teeth cleanings, free whitening and xrays, as well as significant discounts on other dental procedures. After purchasing the plan, there is a discount savings of 20% off all additional treatment.

Plan Benefit Details:

- Free initial exam and full mouth xrays
- Free standard cleanings (2 per year)
- Two free fluoride treatments
- 20% off all additional dental procedures

Cost:

- Primary member \$328
- Each additional family member \$288