Elegant Dentistry

PATIENT REGISTRATION

Name: _____ SSN #: _____-_____-_____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _(_____) _____-_____

Cell: _(_____) _____-_____ Email: _____

To receive text messages please text "TEXT ME" to elegantdentistryscw@gmail.com from your cell phone

DOB: _____/_____/_____ Sex: F M Single Married Divorce Child

Patient Employed By: _____ Occupation: _____

Business Address: _____

City: _____ State: _____ Zip: _____ Phone: _(_____) _____-_____

Emergency Contact: _____ Phone: _(_____) _____-_____

Whom may we thank for referring you? _____

DENTAL HISTORY

What would you like us to do today? _____

Date of Last Dental Care: _____/_____/_____ Date of Last X-Rays: _____/_____/_____

PLEASE CIRCLE IF YOU HAVE HAD ANY OF THE FOLLOWING:

Bad Breath Bleeding Gums Clicking or Popping Jaw Food collection in between teeth

Hot sensitivity Cold sensitivity Sweet sensitivity Biting sensitivity

Grinding/Clinching Sores or growths in mouth Previous Periodontal Treatment

Have often do you brush? _____ Floss? _____

How do you feel about the appearance of your teeth? _____

DENTAL INSURANCE

Insured Person: _____ Relation to Patient: _____

Date of Birth: _____/_____/_____ SSN #: _____-_____-_____

Address (if different from above): _____

City: _____ State: _____ Zip: _____ Phone: _(_____) _____-_____

Cell: _(_____) _____-_____ Email: _____

Employed By: _____ Occupation: _____

Insurance Co: _____ Phone: _(_____) _____-_____

Ins Co Address: _____ City: _____ State: _____ Zip: _____

Subscriber ID#: _____ Group #: _____

13925 West Meeker Boulevard, Suite 1A · Sun City West, AZ 85375 · Phone: (623)584- 0733 · Fax: (623) 584-1799

Elegant Dentistry

MEDICAL HISTORY

Name: _____ DOB: _____/_____/_____
Date of last medical exam: _____/_____/_____
Have you had any serious illnesses or operations? YES NO If YES please describe: _____
_____
Are you currently under a physicians care? YES NO If YES, please describe: _____
_____
Preferred pharmacy _____ major crossroads _____

PLEASE CIRCLE IF YOU CURRENTLY HAVE ANY OF THE FOLLOWING:

Artificial Heart Valves	AIDS/HIV Positive	Psychiatric Care	Dental Phobic
Aspirin _____mg	Cardiac Transplant	Blood Thinners	Liver Disease
High Blood Pressure	High Cholesterol	Tobacco Habit	Pace Maker
Seizures or Fainting	Hard of Hearing	Hemophilia	Pregnant
Congenital Heart Disease	Thyroid Disease	Dementia	Asthma
Previous Infectious Endocarditis	Kidney Disease	Cancer	Stroke

Mitral Valve Prolapse with Regurgitation Hepatitis: A B C MRSA

Bone Replacement Meds - Date: _____ Other: _____

Artificial Joints: _____ Date: _____ Diabetes: Type 1 Type 2

Have you ever had an adverse reaction to a medical or dental procedure? NO YES

If yes, please explain: _____

Is the patient currently taking any medications (INCLUDING OVER THE COUNTER & HEALTH FOOD SUPPLEMENTS?) Please list: _____

_____

Does the patient have any drug allergies? YES NO **If YES, please describe**: _____

_____

AUTHORIZATION

I understand the notice of practices and give my permission to Elegant Dentistry to mail my unsealed postcard to remind me of my appointment.

I consent to treatment, as necessary, to care for the patient named above. I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge and is only for use in my treatment, billing or processing of insurance benefits. I authorize the insurance company to pay the dentist all insurance benefits otherwise payable to me.

I authorize the dentist to release all information necessary to secure payment of benefits. I understand that I am financially responsible for all charges whether paid or not by insurance. All patients are required to take full mouth series x-rays or FMX, at their first complete exam appointment and every 3 to 5 years; depending your oral and medical health. Bitewing x-rays are required minimum once a year.

Signature: _____ Date: _____/_____/_____

PAYMENT IN FULL IS DUE AT THE TIME OF TREATMENT

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Elegant Dentistry

INSURANCE POLICY

We believe that you deserve the best care. That's why we always present you with the best dental solutions possible to treat your personal situation. Each year we provide outstanding dental care to hundreds of patients. Some have dental insurance but some don't. If you have dental benefits, congratulations! You are very fortunate. Here are some important things you should know:

Please Initial:

- _____ Your dental benefits are based upon a contract made between you and/or your (former) employer and an insurance company. **If you have questions regarding your dental benefits please contact your employer or insurance company directly. Dental benefits will not pay 100% of you dental care. It is meant to assist you.**
- _____ We currently accept most private care insurance plans (plans that don't require you to select a dentist from a list) and several PPO's (plans that we are contracted with). This means we work with literally thousands of companies. Although we maintain computerized histories of payment by a given company, they do change; therefore it is impossible to give you a guaranteed quote at the time of service. We estimate our portion based on the most up-to date information we have, but it is **ONLY AN ESTIMATE.** If you would like, we can file a "pre-treatment authorization" with your insurance company prior to that start of treatment. Keep in mind this is not a guarantee of coverage. It does delay treatment but will give you the estimated out-of-pocket figures you are looking for.
- _____ **We bill your insurance as a courtesy.** If insurance does not pay within 90 days, we reserve the right to request payment in full for services from you and let you collect the insurance funds that are due to you. This is rare but it is important that you recognize that the insurance you have is a legal contract between YOU and your insurance company. Our office is not and cannot be a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.
- _____ Our office does require payment in full for your portion **AT THE FIRST SCHEDULED APPOINTMENT.** We accept Cash, Check, Visa, MasterCard, Discover and Debt card. If you are in need of an extended financing option, we also work with Care Credit, who offers 6 or 12 months "same as cash" or longer terms with interest on approved credit.
- _____ A specific amount of time is reserved for you and we strongly encourage all patients to keep their appointments. If you must change you appointment, we require at least **24 hours** notice to avoid a **$57/hour cancellation fee.** (emergencies are an exception, to be determined by our office)

PRIVACY AGREEMENT

I understand the Notice of Privacy Practices and give permission to Elegant Dentistry to mail my unsealed postcard to remind me of my appointment. This office has the most modern equipment, uses the latest up to date techniques and follows OSHA guidelines in sterilization technology for both staff and patient protection.

I agree with the above conditions.

Signature: _____ Date: _____/_____/_____

Patient Name (please print): _____

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