Patient Registration

Date _____ Home Phone _____

Email Address _____ Cell Phone _____

Patient's Name [Mr/Mrs/Ms/Dr]_____ Preferred _____

Mailing Address _____ City _____ State _____ Zip _____

Sex ▫ M ▫ F ▫ Other **Date of Birth** _____ ▫ Single ▫ Married ▫ Widowed ▫ Divorced ▫ Separated

Employer _____ Occupation _____SSN_____

Business Address _____ Business Phone _____

Spouse's Information:

Name _____ Date of Birth _____ SSN _____

Employer _____ Occupation _____

Business Address _____ Business Phone _____

Who is responsible for this account? _____ Relationship to Patient _____

Name of Dental Insurance _____ Group Number _____

Emergency Contact _____ Phone _____ Relationship _____

How did you hear about our office? _____

Acknowledgement of Receipt of Notice of Privacy Practices

I, (print name)_____, have received a copy of this office's Notice of Privacy Practices.

Under the requirements of HIPAA, we are not allowed to give medical/dental information to anyone without the patient's consent. If you wish to have any of your medical/dental information released to family members or friends, please list the individual(s) below:

Name _____ Phone _____ Relationship _____

Name _____ Phone _____ Relationship _____

How would you like for us to communicate with you? Our dental office sends appointment reminders, information about treatment, insurance information and other communications.

Permissible methods of contact (check all that apply):

- ▫ Call me: ▫ Home ▫ Cell ▫ Other _____
- ▫ Text me
- ▫ Email me
- ▫ Do not contact

Please circle your preferred method of contact.

If unable to reach me, please leave: ▫ a detailed message ▫ a message asking me to return the call

For Phone, Text and Email Communications:
By signing below, I consent to the dental practice or its service provider to contact me and/or specialists to provide health care information such as appointment reminders and information about treatment, payment, my account or insurance, using artificial or prerecorded voice or telephone equipment that may be capable of automatic dialing. I understand that the release of information will remain in effect until I provide further written notice.

Signature _____ Date _____

Medical History

Physician's Name _____ Phone Number _____ Last Visit _____

Have you had any serious illnesses or operations? _____ If yes, describe _____

Women: Are you pregnant? ▢ Yes ▢ No Nursing? ▢ Yes ▢ No Taking birth control pills? ▢ Yes ▢ No

Have you had or have any of the following:

- ▢ **AIDS/HIV Positive**
- ▢ **Arthritis**
- ▢ **Artificial Heart Valve**
  If so, when? _____
- ▢ **Artificial Joint**
  If so, when? _____
- ▢ **Asthma**
- ▢ **Blood Disorder**
  - ▢ **Anemia**
  - ▢ **Hemophilia**
  - ▢ **Other_____**
- ▢ **Cancer**
  Type: _____
- ▢ **Chemical Dependency**
- ▢ **Chemotherapy**
- ▢ **Cortisone Treatment**
- ▢ **Cough, persistent**
- ▢ **Diabetes**
- ▢ **Epilepsy**
- ▢ **Fainting**
- ▢ **Gastrointestinal**
  - ▢ **Acid Reflux**
  - ▢ **Other _____**
- ▢ **Headaches**
- ▢ **Hepatitis**
- ▢ **Heart Problems**
  Type:_____
- ▢ **High Blood Pressure**
- ▢ **High Cholesterol**
- ▢ **Kidney Disease**
- ▢ **Lyme Disease**
- ▢ **Nervous System Problems**
- ▢ **Osteoporosis**
  - ▢ **Bone-modifying drugs**
- ▢ **Pacemaker**
- ▢ **Psychiatric Care**
- ▢ **Radiation Treatment**
- ▢ **Respiratory Disease**
- ▢ **Sleep Apnea**
  - ▢ **CPAP**
- ▢ **Shortness of Breath**
- ▢ **Snoring**
- ▢ **Stroke**
- ▢ **Swelling of Feet/Ankle**
- ▢ **Thyroid Problems**
- ▢ **Tobacco Habit**
  Frequency _____
- ▢ **Tuberculosis**

List of Medications

- ❖ _____
- ❖ _____
- ❖ _____
- ❖ _____
- ❖ _____
- ❖ _____
- ❖ _____
- ❖ _____
- ❖ _____
- ❖ _____
- ❖ _____
- ❖ _____
- ❖ _____
- ❖ _____
- ❖ _____
- ❖ _____

Drug Allergies

- ☐ Penicillin/Amoxicillin
  Reaction: _____
- ☐ Erythromycin
  Reaction: _____
- ☐ Clindamycin
  Reaction: _____
- ☐ Codeine
  Reaction: _____
- ☐ Local Anesthetic
  Reaction: _____
- ☐ Sulfa
  Reaction: _____
- ☐ Latex
  Reaction: _____
- ☐ Other _____
  Reaction: _____

Pharmacy _____ Address _____ Phone Number _____

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in completion of this form.

Signature _____ Date _____

For future updates:	*Signature*	*Date*
I have reviewed my health history and have made all pertinent changes to it.		
I have reviewed my health history and have made all pertinent changes to it.		
I have reviewed my health history and have made all pertinent changes to it.		

Dental Health History

Patient Name _____ Today's Date _____

Reason for Today's Visit _____

Former Dentist _____ Address _____

Date of last dental visit _____ Date of last x-rays _____

Any issues with dental treatment? _____ If so, please elaborate _____

Have you had or have any of the following:

- ▢ **Bad breath**
- ▢ **Bleeding gums**
- ▢ **Periodontal treatment**
- ▢ **Sores or growths in mouth**
- ▢ **Clicking or popping of jaw**
- ▢ **Grinding teeth**
- ▢ **Jaw pain**

Sensitivity/pain:

- ▢ **to hot/cold**
- ▢ **when brushing**
- ▢ **when biting**

How often do you brush _____ How often do you floss _____

Ever had a dental appliance?_____ If so, what kind _____ Date _____

Primary Insurance

Name of Policy Holder _____ Policy Holder's Birthdate _____

Policy Holder's Employer _____ Relationship to Patient _____

Policy Holder's Address (if different than patient's) _____

Dental Insurance Company _____

Group #_____ Subscriber #_____

Additional Insurance

Is the patient covered by additional insurance? ▢ **Yes** ▢ **No**

Name of Policy Holder _____ Policy Holder's Birthdate _____

Policy Holder's Employer _____ Relationship to Patient _____

Policy Holder's Address (if different than patient's) _____

Dental Insurance Company _____

Group #_____ Subscriber #_____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above company or companies and assign directly to Charlottesville Dental Associates, Inc. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize the doctor to release all information necessary to secure payment. I authorize the use of this signature on all insurance submissions.

Signature _____ Relationship _____ Date_____

PATIENT FINANCIAL RESPONSIBILITY, ASSIGNMENT AND RELEASE AGREEMENT

Dental treatment is an excellent investment in you and your family's health and wellbeing. We recognize that long range economy is of prime concern as well. The following rights and responsibilities are outlined below to aid in understanding our future dental relationship.

INSURANCE VERIFICATION AND ASSIGNMENT

- I certify that the information I have provided about my active dental insurance coverage is correct to the best of my knowledge.
- I authorize the release of any dental/medical records or other information including diagnosis and treatment rendered to me, as requested by my dental insurance carrier.
- I authorize assignment of benefit payment(s) from my insurance carrier(s) directly to the assigned dental office and the practitioner who provided service(s) to me.

Patients Initials_____

FINANCIAL RESPONSIBILITY

I understand that PAYMENT IN FULL is expected at the time of my appointment. I understand that if I come on the day of my appointment without one of the acceptable forms of payment listed below, the office has the right to reschedule my appointment. We also believe financial considerations should not be an obstacle to obtaining treatment. In situations involving large treatment plans, we provide the following payment options.

CASH, PERSONAL AND BANK CHECKS, AS WELL AS ALL MAJOR CREDIT CARDS. Returned checks will be charged a $35.00 NSF fee on the patient account.

In the event the charges incurred are not paid in full when due and collection action is instituted, I understand I am responsible for the additional costs associated with such collection activity. The collection costs may include and are not limited to collection agency fees, attorney fees, court costs and/or any other expenses incurred in its collection as allowable by law.

CANCELED AND MISSED APPOINTMENTS

I understand that if I find it impossible to keep a scheduled appointment, I must let the office know at least TWENTY-FOUR HOURS in advance so that another patient may use the time reserved for me. There will be a $50 deposit fee after TWO missed appointments to hold your future appointment. The deposit fee will be used towards your treatment, unless you fail to show again, then it will be forfeited. We reserve the right to charge a $50 fee for any missed and/or broken appointments.

PATIENTS WHO HAVE DENTAL INSURANCE BENEFITS

Payment is expected on the day of treatment unless other arrangements have been made prior to the appointment. As a COURTESY, we will submit the fees for your treatment to your insurance company on your behalf. However, the financial responsibility and legal obligation for any uncovered treatment remains with you, including any remaining balance, even though an estimated co-payment may be collected at the time of your appointment. We will attempt to gain as many benefits as possible from your insurance for the services provided but your insurance policy is a contract between you and your insurance company; we are not a party to that contract. We accept assignment of benefits as a courtesy to our patients. Any claim not paid by your insurance carrier within 60 days will be billed to you, the patient.

If needed, a pre-treatment estimate will be sent to your insurance company to determine what benefit you may receive. Patients are responsible for any 'patient portion' not covered by insurance, which will be due at the time of service. Please be advised, this is an ESTIMATE and not a promise or guarantee of coverage from the insurance carrier.

RELEASE

I consent to clinical examination and the making of video, photographs, and x-rays before, during, and after treatment, and to the use of same by doctor in scientific papers or demonstrations. I certify I have read, or had read to me, the contents of this form and realize the risks and limitations involved.

_____ _____

Patient/Responsible Party Signature Date Practice Representative Date