V DENTAL

Patient Registration

Today's Date _____

Last Name _____ First Name _____ MI _____ Date of Birth _____ Age ____

Sex M or F Soc. Sec. # _____ Please Circle One: Single Married Separated Widow

Mailing Address _____ City _____ State ____ Zip Code _____

Email _____ Home Phone (_____)_____ Cell Phone (_____)_____

Driver's License # _____ Employer _____

Work Phone (_____)_____ Occupation _____

Are you a full time student? Yes or No If patient is a minor: Mother's DOB _____ Father's DOB _____

Name of Parent _____ Parent Soc. Sec. # _____

Parent Employer _____ Parent Phone (_____)_____

Person Responsible for Account _____ Relationship _____

Emergency Contact _____ Relationship _____ Phone # (_____)_____

If you are filling this form out on behalf of another person, what is your relationship to that person?

Name _____ Relationship _____

Reason for today's visit? _____

How did you hear about us?

☐ In-home Mailer ☐ Social Media ☐ Insurance ☐ Practice Website ☐ Internet ☐ Family/Friend/Coworker

☐ Other_____ *Who can we thank for your visit?* _____

Dental Insurance Information (Primary Carrier)

Insured's Name _____

Insured's Employer _____

Insured's DOB _____

Insurance Co _____

Insurance Co Address _____

Insurance Phone # _____

Group # _____ Local # _____

Dental Insurance Information Secondary Coverage

Insured's Name _____

Insured's Employer _____

Insured's DOB _____

Insurance Co _____

Insurance Co Address _____

Insurance Phone # _____

Group # _____ Local # _____

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
1. hospitalization for illness or injury _____	☐	☐
2. an allergic or bad reaction to any of the following:	☐	☐
○ aspirin, ibuprofen, acetaminophen, codeine _____		
○ penicillin _____		
○ erythromycin _____		
○ tetracycline _____		
○ sulfa _____		
○ local anesthetic _____		
○ fluoride _____		
○ chlorhexidine (CHX) _____		
○ Iodine _____		
○ metals (nickel, gold, silver, _____)		
○ latex _____		
○ nuts _____		
○ fruit _____		
○ milk _____		
○ red dye _____		
○ other _____		
3. heart problems, or cardiac stent within the last six months _____	☐	☐
4. history of infective endocarditis _____	☐	☐
5. artificial heart valve, repaired heart defect (PFO) _____	☐	☐
6. pacemaker or implantable defibrillator _____	☐	☐
7. orthopedic or soft tissue implant (e.g joint replacement, breast implant) ___	☐	☐
8. heart murmur, rheumatic or scarlet fever _____	☐	☐
9. high or low blood pressure _____	☐	☐
10. a stroke (taking blood thinners) _____	☐	☐
11. anemia or other blood disorder _____	☐	☐
12. prolonged bleeding due to a slight cut (or INR > 3.5) _____	☐	☐
13. pneumonia, emphysema, shortness of breath, sarcoidosis _____	☐	☐
14. chronic ear infections, tuberculosis, measles, chicken pox _____	☐	☐
15. breathing problems (e.g. asthma, stuffy nose, sinus congestion) _____	☐	☐
16. sleep problems (e.g. sleep apnea, snoring, insomnia, restless sleep, bedwetting) __	☐	☐
17. kidney disease _____	☐	☐
18. liver disease or jaundice _____	☐	☐
19. vertigo (e.g. "the room is spinning") _____	☐	☐
20. thyroid, parathyroid disease, or calcium deficiency _____	☐	☐
21. hormone deficiency or imbalance (e.g. poly cystic ovarian syndrome) ____	☐	☐
22. high cholesterol or taking statin drugs _____	☐	☐
23. diabetes (HbA1c = _____) _____	☐	☐
24. stomach or duodenal ulcer _____	☐	☐
25. digestive or eating disorders (e.g. celiac disease, gastric reflux, bulimia, anorexia) _____	☐	☐

	YES	NO
26. osteoporosis/osteopenia or ever taken anti-resorptive medications (e.g. bisphosphonates) _____	☐	☐
27. arthritis or gout _____	☐	☐
28. autoimmune disease (e.g. rheumatoid arthritis, lupus, scleroderma) _____	☐	☐
29. glaucoma _____	☐	☐
30. contact lenses _____	☐	☐
31. head or neck injuries _____	☐	☐
32. epilepsy, convulsions (seizures) _____	☐	☐
33. neurologic disorders (e.g. Alzheimer's disease, dementia, prion disease) _	☐	☐
34. viral infections and cold sores _____	☐	☐
35. any lumps or swelling in the mouth _____	☐	☐
36. hives, skin rash, hay fever _____	☐	☐
37. STI/STD/HPV _____	☐	☐
38. hepatitis (type ____) _____	☐	☐
39. HIV/AIDS _____	☐	☐
40. tumor, abnormal growth _____	☐	☐
41. radiation therapy _____	☐	☐
42. chemotherapy, immunosuppressive medication _____	☐	☐
43. emotional difficulties _____	☐	☐
44. psychiatric treatment or antidepressant medication _____	☐	☐
45. concentration problems or ADD/ADHD _____	☐	☐
46. alcohol/recreational drug use _____	☐	☐
ARE YOU:		
47. presently being treated for any other illness _____	☐	☐
48. aware of a change in your health in the last 24 hours (e.g., fever, chills, new cough, or diarrhea) _____	☐	☐
49. taking medication for weight management _____	☐	☐
50. taking dietary supplements, vitamins, and/or probiotics _____	☐	☐
51. often exhausted or fatigued _____	☐	☐
52. experiencing frequent headaches or chronic pain _____	☐	☐
53. a smoker, smoked previously or other (e.g. smokeless tobacco, vaping, e-cigarettes, and cannabis) _____	☐	☐
54. considered a touchy/sensitive person _____	☐	☐
55. often unhappy or depressed _____	☐	☐
56. taking birth control pills _____	☐	☐
57. currently pregnant _____	☐	☐
58. diagnosed with a prostate disorder _____	☐	☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections) _____

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

Drug	Purpose	Drug	Purpose

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 _____

ASA _____ **(1-6)** 

DENTAL HISTORY

Patient Name _____ Nickname _____ Age _____

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) [____]	☐	☐
2. Have you had an unfavorable dental experience?	☐	☐
3. Have you ever had complications from past dental treatment?	☐	☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic?	☐	☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age?	☐	☐
6. Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma?	☐	☐
GUM AND BONE		
7. Do your gums bleed sometimes or are they ever painful when brushing or flossing?	☐	☐
8. Have you ever had or been told you have gum disease, gum or bone loss between your teeth, or had scaling and root planing?	☐	☐
9. Have you ever noticed an unpleasant taste or odor in your mouth?	☐	☐
10. Is there anyone with a history of periodontal disease in your family?	☐	☐
11. Have you ever experienced gum recession, or can you see more of the roots of your teeth?	☐	☐
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?	☐	☐
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth?	☐	☐
TOOTH STRUCTURE		
14. Have you had any cavities within the past 3 years?	☐	☐
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?	☐	☐
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?	☐	☐
17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?	☐	☐
18. Do you have grooves or notches on your teeth near the gum line?	☐	☐
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?	☐	☐
20. Do you frequently get food caught between any teeth?	☐	☐
BITE AND JAW JOINT		
21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	☐	☐
22. Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together?	☐	☐
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?	☐	☐
24. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed?	☐	☐
25. Are your teeth becoming more crooked, crowded, or overlapped?	☐	☐
26. Are your teeth developing spaces or becoming more loose?	☐	☐
27. Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together?	☐	☐
28. Do you place your tongue between your teeth or close your teeth against your tongue?	☐	☐
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	☐	☐
30. Do you clench or grind your teeth together in the daytime or make them sore?	☐	☐
31. Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth?	☐	☐
32. Do you wear or have you ever worn a bite appliance?	☐	☐
SMILE CHARACTERISTICS		
33. Is there anything about the appearance of your mouth (smile, lips, teeth, gums) that you would like to change (shape, color, size, display)?	☐	☐
34. Have you ever bleached (whitened) your teeth?	☐	☐
35. Have you felt uncomfortable or self conscious about the appearance of your teeth?	☐	☐
36. Have you been disappointed with the appearance of previous dental work?	☐	☐

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Policies for Patients

Payment for Services

Payment in Full is due at the time of service. We accept most major credit cards, Checks, Money Orders or Cash. We also offer payment plans using Care Credit for six (6) months or twelve (12) months deferred interest. Our bank charges a fee for deposited checks with insufficient funds, therefore you will be charged $35 for each returned check.

_____ **(Initial Here)** ***I understand the above policy and agree to the terms herein.***

Dental Insurance

Your insurance coverage is a contract between you or your employer and the insurance company. We take pride in providing you with the best dental care based only on your dental needs, not based on your insurance coverage. We will give you an estimated co-payment amount which is to be paid on the date of service. We will submit claims under one primary and one secondary dental insurance plan. Please provide us with the most current insurance information prior to each appointment in order for us to give you the best estimate of your benefits. If for any reason we have not received your insurance payment or if your insurance plan does not cover procedures as estimated for any reason, the portion not covered and any remaining balance is your responsibility at 60 days. In the event that your insurance should pay us after that time, you will be reimbursed. If the insurance company sends you payment for services, it is your responsibility to deposit the check and then bring in the EOB and payment to apply to your account. If it becomes necessary to refer your overdue balance to a 3rd party for collection, you will be responsible for any additional fees or court costs. By signing this document, I am agreeing to the assignment of benefits from insurance to be payable to V Dental.

_____ **(Initial Here)** ***I understand the above policy and agree to the terms herein.***

Late, Missed or Cancelled Appointments

Quality dental care requires that we set aside an adequate amount of time for our Doctors or Hygienists to complete the planned procedure in the best way possible. This requires careful planning of our daily schedule in advance. Patients that make last minute changes to our schedule or run late to an appointment affect our ability to run on schedule with other on-time patients. For this reason:

- Prior notice of at least **48 hours (2 business days)** is required to cancel or reschedule any appointment.
- Arriving more than 10 minutes late may require your appointment to be rescheduled or limit our ability to complete the schedule treatment.
- A missed, cancelled or late appointment fee of $50 will applied for each patient.
- Repeated missed, cancelled or late appointments may require that you prepay for your appointments.

For patients that have difficulty with scheduling or arriving on time, we will no longer pre-book your appointments. You will be added to our Priority Reservation List. Patients on this list will be offered appointments that other patients have given up without proper notice. When you are contacted, you may choose this appointment time or choose to remain on the list until a more convenient appointment opens up.

_____ **(Initial Here)** ***I understand the above policy and agree to the terms herein.***

Confirmation of Appointments

Due to high demand from our loyal patients, it is imperative that our office be able to confirm your appointment prior to the day of appointment. If we are unable to confirm your appointment at least **48 hours (2 business days)** prior, your appointment **will be cancelled** to allow us to accommodate patients waiting to see us. We use automated text messaging and emails in addition to personal phone calls in an attempt to confirm your appointment.

_____ **(Initial Here)** ***I understand the above policy and agree to the terms herein.***

****It is your legal option to not sign this acknowledgement, however our policy states that if we do not have this signed acknowledgement from you, we will not be able to provide you with our services. ****

Treatment Appointments

An appointment that exceeds 90 minutes will require a deposit, in order to reserve that appointment.

_____ **(Initial Here)** ***I understand the above policy and agree to the terms herein.***

Referrals

Should you be referred out to see any of our preferred recommended specialists, our office only focuses on giving you the option of the best quality care for your treatment. We are not responsible for their fees and it is up to the patient to follow up with that office or insurance company to see if they are in your plans network.

_____ **(Initial Here)** ***I understand the above policy and agree to the terms herein.***

Unattended Children

We love seeing children as patients! While your child is having a dental visit, we ask that parents/guardians either remain in the treatment room with their child or stay in the waiting room. You need to **monitor other children if there are multiple children** present, or there needs to be another responsible adult (over 18) supervising the other children. For the wellbeing and safety of your children, the consideration of our dental staff, and for the consideration of other patients, we reserve the right to reschedule patients who do not adhere to the following policies:

- **Any person under the age of 18 must have a parent or legal guardian present at all times in the office. (No dropping off children).**
- No child under the age of 12 may be left unattended by a legal guardian outside of the treatment room.
- Only one adult family member may be present in the dental treatment room during a child's treatment, if they choose to. Other children/siblings may be present only for annual exams so long as they are not disruptive in the treatment room.

- You **may not schedule your own dental treatment** with a baby or child under the age of 12 present in the dental treatment room or in the office. Another adult parent or guardian must be present to monitor them.

Unlike most dental offices, we encourage a parent to be present in the treatment room for all children. However, we reserve the right to ask a parent to wait in the reception area with any children not in the dental chair for treatment, if multiple children are present or if they become disruptive to care or disturb other patients.

_____ **(Initial Here)** ***I understand the above policy and agree to the terms herein.***

Please initial the following before signing:
_____ I give permission for Doctors and the staff of V Dental to discuss my dental care with the following adult family member:_____
_____I have read and agree to the Privacy/HIPAA policies. I will be provided with a written copy upon request on my first visit.
_____I agree to allow the communication (email, fax, electronic transmission or phone) of protected health information to my insurance company, for specialty referrals or to the patient or person(s) listed above.

By signing below, I acknowledge and agree to the above policies for myself and all family members under 18 or under my legal care.

_____ _____
Signature of Patient/Guardian **Witness (Staff Printed Name)**

_____ _____
Printed Name **Date**

If signatory is under 18, the parent or legal Guardian must sign to signify agreement.
****It is your legal option to not sign this acknowledgement, however our policy states that if we do not have this signed acknowledgement from you, we will not be able to provide you with our services. ****