REGISTRATION FORM

Section I **Patient Information** **Date**______________________

Name:____ I Prefer to be called: ________________________________
Address:____City:______________________State:_________Zip______________
Date of Birth:_____________________________ Social Security Number:_______________________________
Check Appropriate Box: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Domestic Partner

Cell Phone (______)_______________________Textable? ☐ Yes ☐ No Other phone (______)________________________
Email Address____ Can we send you appointment emails? ☐ Yes ☐ No

Whom may we thank for referring you? ____
Person to contact in case of emergency_______________________________________ Phone____________________________

Section II **Insurance Information**

Primary Insurance

Name of Insured__________________________________
DOB____
SSN#:____
Relationship to Patient ______________________________
Name of Employer_________________________________
Insurance Company________________________________
Group #____
ID#____

Secondary Insurance (If applicable)

Name of Insured__________________________________
DOB____
SSN#:____
Relationship to Patient ______________________________
Name of Employer_________________________________
Insurance Company________________________________
Group #____
ID#____

Section III **Financial Information and Assignment of Benefits Authorization**

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. If my dental insurance company does not remit payment within 60 days, the balance of my account will be due in full from me and I will be asked to follow up with my insurance company. I understand that my secondary insurance cannot be billed until a primary insurance explanation of benefits is received by this office. I understand that I am responsible for all costs of dental treatment and have had the opportunity to discuss the financial policy of this office.

I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic, and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals.

I hereby assign all rights and benefits under my dental insurance contract to Greenview Dental Care for the purpose of determining the details of the benefits of this policy and obtaining payment for services given. This assignment further permits Greenview Dental Care to obtain all information necessary for the determination of benefits allowed under the contract and permits the direct disclosure to Greenview Dental Care of all information including benefits provided, limits and exclusions of benefits and reasons for denial of benefits or reduction in charges for services rendered. This assignment shall allow Greenview Dental Care to take all action necessary to obtain the benefits I have, in good faith. All benefits are to be paid directly to Greenview Dental Care. If my current policy prohibits direct payment to Dr, then I hereby also instruct and direct you to make out the check to me and mail it care of the Doctor. A photocopy of this assignment shall be considered as effective and valid as the original.

I further authorize Greenview Dental Care to initiate a complaint to the Insurance Commissioner's office for any reason on my behalf. This assignment shall remain in effect for the duration of treatment and any additional time necessary to secure full payment for services rendered. This is a direct assignment of my rights and benefits under this policy.

X____ **Date** ____________________________
Patient Signature

(over)

CONFIDENTIAL HEALTH HISTORY

Dental History

Primary reason for today's dental appointment: ☐ New patient examination/cleaning ☐ Emergency ☐ Consultation only

What type of dental care are you looking for? ☐ Fix what's broken ☐ Routine care ☐ Cosmetic (whitening, Invisalign, smile design)

Do you have a specific dental problem? Describe ____________________ Yes No
Do you have routine dental examinations? Last visit ____________________ Yes No
Do you think you have active decay or gum disease? ____________________ Yes No
Do your gums ever bleed? ____________________ Yes No
Do you like your smile? ____________________ Yes No
Does food catch between your teeth? ____________________ Yes No
Do you ever have discomfort, clicking, or popping in your jaw joints? ____________________ Yes No
Do you smoke or chew? ____________________ Yes No
Have you had problems with prior dental treatments? ____________________ Yes No
Date of last dental exam ____________________ Name of last treating dentist ____________________

Medical History

Is your general health good? If no, explain ____________________ Yes No
Has there been a change in your health within the last year? If yes, explain ____________________ Yes No
Have you ever been hospitalized or had a major operation? If yes, explain ____________________ Yes No
Are you being treated by a physician now? If yes, explain ____________________ Yes No
Are you taking any medications, pills or drugs? Please list ____________________ Yes No
____
Are you allergic to any of the following: ☐ Latex ☐ Penicillin ☐ Codeine ☐ Aspirin ☐ Local Anesthetic ☐ Vicodin ☐ Metal ☐ Food
Other allergies ____________________
WOMEN ONLY: Pregnant? __________ Due Date __________ Nursing? __________ Birth Control Pills? __________

Have you had or do you have any of the following? Please circle YES or NO for each.

AIDS/HIV	yes/no	Chest Pain (Angina)	yes/no	Heart Problems	yes/no	Rheumatic Fever	yes/no
Allergies (medication)	yes/no	Circulatory Problems	yes/no	Hepatitis Type______	yes/no	Scarlet Fever	yes/no
Allergies (pollen/dust)	yes/no	Congenital Heart Problems	yes/no	High Blood Pressure	yes/no	Shortness of Breath	yes/no
Anemia	yes/no	Constipation or Diarrhea	yes/no	Jaundice	yes/no	Sinus Trouble	yes/no
Arthritis, Rheumatism	yes/no	Cortisone Treatment	yes/no	Jaw Pain	yes/no	Skin Rash	yes/no
Artificial Heart Valve	yes/no	Cough, persistent or bloody	yes/no	Kidney Disease	yes/no	Special Diet	yes/no
Artificial Joints	yes/no	Diabetes	yes/no	Liver Disease	yes/no	Stroke	yes/no
Asthma	yes/no	Emphysema	yes/no	Low Blood Pressure	yes/no	Swollen Feet or Ankle	yes/no
Back Problems	yes/no	Epilepsy	yes/no	Mitral Valve Prolapse	yes/no	Swollen Neck Glands	yes/no
Bleeding Problems	yes/no	Fainting or dizziness	yes/no	Nervous Problems	yes/no	Tonsillitis	yes/no
Blood Disease	yes/no	Glaucoma	yes/no	Pacemaker	yes/no	Tumor on head or neck	yes/no
Cancer	yes/no	Headaches	yes/no	Psychiatric Care	yes/no	Ulcer	yes/no
Chemical Dependency	yes/no	Heart Murmur	yes/no	Radiation Treatment	yes/no	Venereal Disease	yes/no
Chemotherapy	yes/no	Herpes	yes/no	Respiratory Disease	yes/no	Weight loss, unexplained	yes/no

Do you have or have you had other diseases or medical problems NOT listed on this form? ____________________ yes/no
Have you ever been pre-medicated for dental treatment? If YES, when: ____________________ yes/no
Have you ever taken Fen-Phen (diet pill)? If YES, when: ____________________ yes/no
Is there any issue or condition that you would like to discuss with the dentist in private? ____________________ yes/no

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the dentist and staff at the next appointment without fail.

X____________________ **Date** ____________________
Patient Signature

Dentist's Signature and Date