PATIENT REGISTRATION

PATIENT INFORMATION

Name: _____ Soc. Sec. #: _____
LAST FIRST MIDDLE

Driver's Lic. #: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____ Phone Number: _____

Sex: ☐ M ☐ F Date of Birth: _____ ☐ Single ☐ Married ☐ Partnered ☐ Widowed ☐ Child

Patient's Employer: _____ Occupation: _____

Business Phone: _____ How did you hear about Bling Dental? _____

In case of emergency who should be notified? _____ Phone: _____

What is your preferred method for us to contact with you? ☐ Phone ☐ Call ☐ Text ☐ Email

I need to be aware of all dental costs up front: ☐ Yes ☐ No

PRIMARY DENTAL INSURANCE

Person Responsible for Account: _____
LAST FIRST MIDDLE

Relation to Patient: _____ Birth Date: _____ Soc. Sec #: _____

Address (*if different than patient's*): _____ Phone: _____

City: _____ State: _____ Zip: _____

Person Responsible for Account's Employer: _____ Occupation: _____

Business Address: _____ Business Phone: _____

Subscriber ID: _____ Group #: _____

SECONDARY DENTAL INSURANCE

Person Responsible for Account: _____
LAST FIRST MIDDLE

Relation to Patient: _____ Birth Date: _____ Soc. Sec #: _____

Address (*if different than patient's*): _____ Phone: _____

City: _____ State: _____ Zip: _____

Person Responsible for Account's Employer: _____ Occupation: _____

Business Address: _____ Business Phone: _____

Subscriber ID: _____ Group #: _____

_____
PATIENT NAME

DENTAL HISTORY

Reason for Today's Visit: _____

Former Dentist: _____ Phone Number: _____

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

Check (✔) if you have had problems with any of the following:

☐ Bad breath	☐ Grinding teeth	☐ Sensitivity to sweets
☐ Bleeding gums	☐ Loose teeth	☐ Sensitivity when biting
☐ Broken fillings	☐ Periodontal treatment	☐ Shredding floss
☐ Clicking popping jaw	☐ Sensitivity to cold	☐ Snoring/sleep apnea
☐ Food collection between teeth	☐ Sensitivity to hot	☐ Sores or growths in your mouth

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

Are you satisfied with overall health of your mouth? ☐ Yes ☐ No

If no, what could be improved? _____

_____

Are you satisfied with the overall look of your smile? ☐ Yes ☐ No

If no, what could be improved: _____

_____

☐ Discoloration ☐ Crowding ☐ Chipping ☐ Gummy smile ☐ Tooth shape ☐ Other _____

Would you like to talk to your dentist about this today? ☐ Yes ☐ No

_____

PATIENT NAME

MEDICAL HISTORY

Women: Are you pregnant/trying to get pregnant? ☐ Yes ☐ No Taking contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Allergic to any of the following? ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other: _____

Do you have, or have you had, any of the following?

Alzheimer's Disease	☐ Yes	☐ No	Fainting Spells/Dizziness	☐ Yes	☐ No	Paranthyroid Disease	☐ Yes	☐ No
Anaphylaxis	☐ Yes	☐ No	Frequent Cough	☐ Yes	☐ No	Psychiatric Core	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Frequent Diarrhea	☐ Yes	☐ No	Radiation Treatments	☐ Yes	☐ No
Angina	☐ Yes	☐ No	Frequent Headaches	☐ Yes	☐ No	Recent Weight loss	☐ Yes	☐ No
Arthritis/Gout	☐ Yes	☐ No	Genital Herpes	☐ Yes	☐ No	Renal Dialysis	☐ Yes	☐ No
Artificial Heart Valve	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Artificial Joint	☐ Yes	☐ No	HIV Positive/AIDS	☐ Yes	☐ No	Rheumatism	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Hay Fever	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	Heart Attack/Failure	☐ Yes	☐ No	Shingles	☐ Yes	☐ No
Blood Transfusion	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Sickle Cell Disease	☐ Yes	☐ No
Breathing Problem	☐ Yes	☐ No	Heart Pace Maker	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Bruise Easily	☐ Yes	☐ No	Heart Trouble/Disease	☐ Yes	☐ No	Spina Bifida	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No	Stomach/Intestinal Disease	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Hepatitis A	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Chest Pains	☐ Yes	☐ No	Hepatitis B or C	☐ Yes	☐ No	Swelling of Limbs	☐ Yes	☐ No
Cold Sores/Fever Blisters	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Thyroid Disease	☐ Yes	☐ No
Congenital Heart	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Disorder	☐ Yes	☐ No	Hives or Rosh	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Convulsions	☐ Yes	☐ No	Hypoglycemia	☐ Yes	☐ No	Tumors or Growlhs	☐ Yes	☐ No
Cortisone Medicine	☐ Yes	☐ No	Irregular Heartbeat	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Kidney Problems	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Drug Addiction	☐ Yes	☐ No	Leukemia	☐ Yes	☐ No	Yellow Jaundice	☐ Yes	☐ No
Easily Winded	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No			
Emphysema	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Other:		
Epilepsy or Seizures	☐ Yes	☐ No	Lung Disease	☐ Yes	☐ No			
Excessive Bleeding	☐ Yes	☐ No	Valve Prolapse	☐ Yes	☐ No	_____		
Excessive Thirst	☐ Yes	☐ No	Pain in Jaw Joints	☐ Yes	☐ No			
			Parathyroid Disease	☐ Yes	☐ No	_____		

_____

PATIENT NAME

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Existing health problems or medication that you may be taking, could have on important interrelationship with the dentistry you will receive. Thank you for answering the following questions:

Are you under a physician's care now? ☐ Yes ☐ No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ☐ Yes ☐ No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No If yes, please explain: _____

Are you on a special diet? ☐ Yes ☐ No If yes, please explain: _____

Do you use tobacco? ☐ Yes ☐ No If yes, please explain: _____

Have you ever taken controlled substances? ☐ Yes ☐ No If yes, please explain: _____

Have you ever taken an antibiotic premedication prior to receiving dental care? ☐ Yes ☐ No

If yes, please explain: _____

PATIENT NAME

We are thrilled that you chose to come to Billing Dental. We will take great care of you.
Is there anything else you would like us to know about you?

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT or GUARDIAN _____ DATE _____

PATIENT NAME

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

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

_____

PLEASE PRINT NAME

_____

SIGNATURE

_____

DATE

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (Please specify)

_____

_____

PATIENT NAME

FINANCIAL AGREEMENT

PLEASE READ CAREFULLY

We are committed in helping all of our patients receive the needed treatment to achieve and maintain optimal dental health. We offer the following financial agreement and payment options.

All estimated fees are due at the time of service

For our patients with dental insurance:

We will gladly process your primary and secondary insurance claims with the following understanding:

Initial ___ * Dental Insurance is an agreement between you and your insurance company; therefore we can only estimate your dental benefits. This estimate is not a guarantee of payment by your insurance company. You are responsible for any charges your insurance company does not pay.

Initial ___ * Your out of pocket portion & deductibles are due at time of service

Initial ___ * Insurance payments not paid after 60 days will become your complete responsibility. You agree to pay your full balance after 60 days from date of service

Financing options:

1. We accept cash and check.
2. We accept all major credit cards.
3. We also offer financing options with no interest payments up to 12 months on approved credit with Care Credit

SIGNATURE OF PATIENT/RESPONSIBLE PARTY DATE

When making appointments at Bling Dental, we specifically reserve time for your care. Please call at least 48 hours prior to your appointment if you need to make a change in your schedule time. This early notification allows us to accommodate other patients who would desire this specific time. Thank you.

PATIENT NAME