



# 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 #: \_\_\_\_\_



## 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:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Bad breath                    | <input type="checkbox"/> Grinding teeth        | <input type="checkbox"/> Sensitivity to sweets          |
| <input type="checkbox"/> Bleeding gums                 | <input type="checkbox"/> Loose teeth           | <input type="checkbox"/> Sensitivity when biting        |
| <input type="checkbox"/> Broken fillings               | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Shredding floss                |
| <input type="checkbox"/> Clicking popping jaw          | <input type="checkbox"/> Sensitivity to cold   | <input type="checkbox"/> Snoring/sleep apnea            |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Sensitivity to hot    | <input type="checkbox"/> 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



## MEDICAL HISTORY (CONTINUED)

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	Parathyroid 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 Disorder	Yes	No	High Blood Pressure	Yes	No	Tonsillitis	Yes	No
Convulsions	Yes	No	Hives or Rosh	Yes	No	Tuberculosis	Yes	No
Cortisone Medicine	Yes	No	Hypoglycemia	Yes	No	Tumors or Growlths	Yes	No
Diabetes	Yes	No	Irregular Heartbeat	Yes	No	Ulcers	Yes	No
Drug Addiction	Yes	No	Kidney Problems	Yes	No	Venereal Disease	Yes	No
Easily Winded	Yes	No	Leukemia	Yes	No	Yellow Jaundice	Yes	No
Emphysema	Yes	No	Liver Disease	Yes	No			
Epilepsy or Seizures	Yes	No	Low Blood Pressure	Yes	No	Other:		
Excessive Bleeding	Yes	No	Lung Disease	Yes	No	_____		
Excessive Thirst	Yes	No	Valve Prolapse	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 an 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





# 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