Ideal Dental Of Tucson

PATIENT REGISTRATION
(TO BE FILLED IN COMPLETELY - PLEASE PRINT)

PATIENT INFORMATION

FULL NAME _____ DATE OF BIRTH _____ AGE _____

HOME ADDRESS _____ HOME PHONE _____ CELL PHONE _____

CITY _____ STATE _____ ZIP CODE _____ EMAIL _____

SOCIAL SECURITY NO. _____ DRIVER'S LICENSE NO. _____

SEX ❑ MALE ❑ FEMALE MARITAL STATUS ❑ SINGLE ❑ MARRIED ❑ DIVORCED ❑ WIDOWED

EMPLOYER _____ ADDRESS _____ BUSINESS PHONE _____

FULL TIME STUDENT YES NO NAME OF SCHOOL _____

NAME OF SPOUSE _____ SPOUSE'S SOCIAL SECURITY NO. _____

SPOUSE'S EMPLOYER _____ ADDRESS _____ BUSINESS PHONE _____

NEAREST RELATIVE NOT LIVING WITH YOU _____ RELATIONSHIP _____

STREET _____ CITY _____ STATE _____ ZIP CODE _____ PHONE _____

FRIEND OR NEIGHBOR IN CASE OF EMERGENCY _____ PHONE _____

REFERRED BY _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ HOME PHONE _____

DRIVER'S LICENSE # _____ BIRTHDATE _____

EMPLOYER _____ WORK PHONE _____ SSN# _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ❑ YES ❑ NO

DENTAL INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE # _____

ID OR POLICYNO. _____ GROUP NO. _____

NAME OF POLICY HOLDER _____

RELATIONSHIP TO PATIENT _____

DATE OF BIRTH _____

DENTAL INSURANCE INFORMATION

SECONDARY INSURANCE CARRIER

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE # _____

ID OR POLICYNO. _____ GROUP NO. _____

NAME OF POLICY HOLDER _____

RELATIONSHIP TO PATIENT _____

DATE OF BIRTH _____

PLEASE NOTE

OUR OFFICE BILLS INDIVIDUALS IN THE SAME HOUSEHOLD UNDER **ONE** ACCOUNT. IF YOU MUST HAVE SEPARATE ACCOUNTS PLEASE NOTIFY THE RECEPTIONIST.

PAYMENT IS DUE UPON RECEIPT OF SERVICES UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE. AS A COURTESY TO OUR PATIENTS. WE WILL FILE PRIVATE DENTAL INSURANCE CLAIMS; HOWEVER. THE CO-PAYMENT AND ANY DEDUCTIBLE SPECIFIED BY YOUR PLAN ARE DUE AT THE TIME OF SERVICE. PLEASE REMEMBER THAT YOU ARE ULTIMATELY RESPONSIBLE FOR PAYMENT OF THE FEES IN THIS OFFICE. PAYMENTS MAY BE MADE BY CASH, CHECK,. VISA/MASTERCARD.

AUTHORIZATION FOR RELEASE OF DENTAL INFORMATION, ASSIGNMENT OF BENEFITS

I AUTHORIZE Dallin Jay Williams D.D.S. TO RELEASE DENTAL INFORMATION FOR INSURANCE PURPOSES CONCERNING TREATMENT or THE ABOVE NAMED PATIENT WHILE UNDER HIS CARE. I AUTHORIZE PAYMENT OF ANY INSURANCE BENEFITS FOR DENTAL SERVICES DIRECTLY TO Dallin Jay Williams. D.D.S. I AGREE TO PAY ANY FEES NOT COVERED BY INSURANCE BENEFITS DIRECTLY TO Dallin Jay Williams D.D.S. UPON DEFAULT; I AGREE TO PAY INTEREST OF 1.75% PER MONTH. 21% A.P.R. IF PAYMENT ARRANGEMENTS HAVE BEEN EXTENDED LONGER THAN 90 DAYS, I UNDERSTAND THAT A $25 PER MONTH STATEMENT FEE WILL BE CHARGED TO MY ACCOUNT. IF THIS ACCOUNT IS REFERRED FOR COLLECTION, I AGREE TO PAY A 33% COLLECTION FEE ON THE AMOUNT OWING. SHOULD LEGAL ACTION BE TAKEN. I AGREE TO PAY REASONABLE ATTORNEY'S FEES AND COURT COSTS IN ADDITION TO THE ABOVE AMOUNTS.

A CHARGE WILL BE MADE FOR CANCELLATIONS WITHOUT 48 HOURS NOTICE ON APPOINTMENTS.

_____ _____
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE

MEDICAL HISTORY

NAME OF PHYSICIAN _____ PHONE NUMBER _____

PLEASE LIST ANY MEDICATIONS CURRENTLY BEING TAKEN _____

PLEASE UST ANY MEDICATIONS PATIENT IS ALLERGIC TO _____

HAS THE PATIENT EVER HAD AN UNUSUAL REACTION TO DENTAL ANESTHESIA? . . . . . ❑ YES ❑ NO

IS THE PATIENT IN GOOD HEALTH? . . . . . ❑ YES ❑ NO

AIDS/H.I.V. POSITIVE	❑ YES	❑ NO	HEART PACEMAKER	❑ YES	❑ NO	MITRAL VALVE PROLAPSE	❑ YES	❑ NO
ANEMIA	❑ YES	❑ NO	HEART (SURGERY, DISEASE, ATTACK)	❑ YES	❑ NO	NERVOUS DISORDERS	❑ YES	❑ NO
ASTHMA	❑ YES	❑ NO	HEART TROUBLE	❑ YES	❑ NO	PROLONGED BLEEDING	❑ YES	❑ NO
BYPASS GRAFT	❑ YES	❑ NO	HEPATITIS A (INFECTOUS)	❑ YES	❑ NO	RADIATION THERAPY	❑ YES	❑ NO
CHEMOTHERAPY	❑ YES	❑ NO	HEPATITIS B (SERUM)	❑ YES	❑ NO	RHEUMATIC FEVER	❑ YES	❑ NO
CHRONIC COUGH	❑ YES	❑ NO	HEPATMS C (SERUM)	❑ YES	❑ NO	SINUS TROUBLE	❑ YES	❑ NO
DIABETES	❑ YES	❑ NO	HIGH BLOOD PRESSURE	❑ YES	❑ NO	SMOKE CURRENTLY	❑ YES	❑ NO
ENDOCRINE PROBLEMS	❑ YES	❑ NO	JOINT REPLACEMENT	❑ YES	❑ NO	SPECIAL DIET	❑ YES	❑ NO
EPILEPSY	❑ YES	❑ NO	KIDNEY INVOLVEMENT	❑ YES	❑ NO	STROKE	❑ YES	❑ NO
FAINTING OR DIZZINESS	❑ YES	❑ NO	LATEX SENSITIVITY	❑ YES	❑ NO	TUBERCULOSIS	❑ YES	❑ NO
HEART MURMUR	❑ YES	❑ NO				. . . . .	❑ YES	❑ NO

FOR WOMEN. ARE YOU: PREGNANT? YES, ____MONTHS NURSING? YES NO TAKING BIRTH CONTROL PILLS? YES NO

DO YOU HAVE OR HAVE YOU HAD ANY DISEASE, CONDITION, OR PROBLEM NOT LISTED? . . . . . ❑ YES ❑ NO

IF YES, PLEASE LIST: _____

DATE REVIEWED _____ _____ DATE REVIEWED _____ _____ DATE REVIEWED _____ _____
INITIALS INITIALS INITIALS

DENTAL HISTORY

REASON FOR VISIT TO THIS OFFICE? _____

HOW LONG SINCE YOUR LAST DENTAL VISIT? _____

DO YOU HAVE ANY DISCOMFORT? _____ ❑ YES ❑ NO

ARE TEETH SENSITIVE TO ❑ HEAT ❑ COLD ❑ PRESSURE ❑ SWEETS? ❑ _____

HAVE THERE BEEN ANY INJURIES TO THE FACE, MOUTH, AND TEETH? . . . . . ❑ YES ❑ NO

DO YOU MAKE REGULAR VISITS TO THE DENTIST? . . . . . ❑ YES ❑ NO

ARE YOU FRIGHTENED DURING DENTAL VISITS? . . . . . ❑ YES ❑ NO

DO YOU PREFER A LOCAL ANESTHETIC (NOVOCAINE) FOR DENTAL PROCEDURES? . . . . . ❑ YES ❑ NO

DO YOU GAG EASILY? . . . . . ❑ YES ❑ NO

DO YOUR GUMS BLEED EASILY?. . . . . ❑ YES ❑ NO

HAVE YOU EVER HAD PERIODONTAL TREATMENT? . . . . . ❑ YES ❑ NO

DO YOU HAVE CLICKING, POPPING OR PAIN WHEN OPENING OR CLOSING JAWS? . . . . . ❑ YES ❑ NO

ARE YOU INTERESTED IN WHITENING YOUR TEETH? . . . . . ❑ YES ❑ NO

ON A SCALE FROM 1 TO 10, 10 BEING THE BEST, HOW DO YOU LIKE THE APPEARANCE OF YOUR TEETH (CIRCLE ONE) 1 2 3 4 5 6 7 8 9 10
LEAST BEST

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____ ' s dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. If payment arrangements have been extended longer than 90 days, I understand that a $25 per month statement fee will be charged to my account. In the event payments are not received by agreed upon dates, I understand that a 1.75% late charge (21% APR) may be added to my account.

Patient or Responsible Party _____ Date _____