DeSoto Family Dentistry

DENTAL REGISTRATION AND HISTORY

Patient Information

Patient: _____

Address: _____

_____
City State Zip

E-Mail:_____

Sex: ☐M ☐F Age: _____ Birthdate: _____

Height: _____ Weight: _____

☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

Patient SS#: _____

Occupation: _____

Employer: _____

Employer Address: _____

_____
City State Zip

Employer Phone: _____

Spouse's Name: _____

Birthdate: _____ SS#:_____

Occupation:_____

Spouse's Employer: _____

Whom may we thank for referring you?

_____

Dental Insurance

Who is responsible for this account:_____

Relationship to Patient:_____

Insurance Co:_____

Group#:_____

Is patient covered by additional insurance? ☐Yes ☐No

Subscriber's Name:_____

Birthdate:_____ SS#:_____

Relationship to Patient:_____

Insurance Co:_____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Responsible Party

_____
Relationship Date

Contact Information

Home: _____ Cell:_____ Work:_____ Ext:_____

Best time to reach you: _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household)

Name: _____ Relationship:_____

Home Phone: _____ Cell Phone:_____ Work Phone:_____

Medications

List medications you are currently taking:

_____

_____

_____

Pharmacy Name: _____

Phone: _____

Allergies

☐ **Aspirin**
☐ **Barbiturates (Sleeping Pills)**
☐ **Codeine**
☐ **Iodine**
☐ **Latex**
☐ **Local Anesthetic**
☐ **Penicillin**
☐ **Sulfa**
☐ **Other:** _____

_____

Reason for today's Visit:

_____

_____

Health History

Physician's Name:_____ Date of Last Visit:_____

Please mark a check on "Yes" or "No" to indicate if you have or had any of the following:

AIDS	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Respiratory Disease	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Arthritis, Rheumatism	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Artificial Heart Valves	☐ Yes ☐ No	Heart Problems	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No
Artificial Joints	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Type_____		Skin Rash	☐ Yes ☐ No
Back problems	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Special Diet	☐ Yes ☐ No
Bleeding Abnormally	☐ Yes ☐ No	Type_____		Stroke	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Swelling of Feet	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	HIV Positive	☐ Yes ☐ No	Or Ankles	
Chemical Dependency	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No	Swollen Neck Glands	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Jaw Pain	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Circulatory Problems	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Congenital Heart Lesions	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Cortisone Treatments	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Tumor or Growth	☐ Yes ☐ No
Cough, Persistent or	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No	On Head or Neck	
Bloody		Nervous Problems	☐ Yes ☐ No	**Women Only:**	
Contact Lenses	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Are you pregnant?	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No			Are you nursing?	☐ Yes ☐ No
Depression/Anxiety	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	Due Date_____	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No		
Epilepsy	☐ Yes ☐ No	Ulcer		Other_____	
Extractions or Surgery	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No	_____	
Fainting or Dizziness	☐ Yes ☐ No	Weight Loss	☐ Yes ☐ No	_____	

Dental History

Reason for today's visit_____

_____

Former Dentist_____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

Please mark a check on "Yes" or "No" to indicate if you have or had any of the following:

Bad Breath	☐ Yes ☐ No	Cigarette/ Pipe/Cigar	☐ Yes ☐ No	Periodontal Treatment	☐ Yes ☐ No
Bleeding Gums	☐ Yes ☐ No	Smoking		Sensitivity to Cold	☐ Yes ☐ No
Blisters on lips/mouth	☐ Yes ☐ No	Clicking /Popping Jaw	☐ Yes ☐ No	Sensitivity to Heat	☐ Yes ☐ No
Burning Sensation on	☐ Yes ☐ No	Dry Mouth	☐ Yes ☐ No	Sensitivity to Sweets	☐ Yes ☐ No
Tongue		Fingernail Biting	☐ Yes ☐ No	Sensitivity when Biting	☐ Yes ☐ No
Chew on one side of	☐ Yes ☐ No	Food Collection	☐ Yes ☐ No	Sores/Growths in	
Mouth		Between Teeth		Mouth	☐ Yes ☐ No
		Foreign Objects	☐ Yes ☐ No	Other: _____	
		Grinding Teeth	☐ Yes ☐ No	_____	
		Gums Swollen/Tender	☐ Yes ☐ No	_____	
		Jaw Pain/Tiredness	☐ Yes ☐ No	**How often do you floss?**	
		Lip/Cheek Biting	☐ Yes ☐ No	_____	
		Loose Teeth	☐ Yes ☐ No	**How often do you brush?**	
		Broken Fillings	☐ Yes ☐ No	_____	
		Mouth Breathing	☐ Yes ☐ No		
		Mouth Pain, Brushing	☐ Yes ☐ No		
		Orthodontic Treatment	☐ Yes ☐ No		
		Pain around the Ear	☐ Yes ☐ No		

NOTE: Both Doctor and patient are encouraged to discuss and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

_____

Signature of Patient/Legal Guardian Date

FOR COMPLETION BY DENTIST

Comments on patient interview concerning health history:_____

_____

Significant finding from questionnaire or oral interview:_____

_____

Dental management considerations:_____

_____ Dr. Initials _____ RDH Initials

Office Policies

Thank you for selecting our office for all of your dental needs. We would like to provide you with some basic information about how our office can accommodate you. We encourage our patients to discuss any questions they may have regarding our policies.

Financial Policies

1. Payment is due at the time of service, unless prior written financial arrangements have been made.
2. Payment forms accepted are: cash, check, CareCredit, or charge. (American Express, Visa, MC, or Discover)
3. There will be a $25 fee for any returned check. Checks cannot be processed more than two times.
4. We will file your insurance claims for your convenience, but you will be responsible for the payment of your *estimated portion* at the time services are rendered.
5. We allow 45 days for outstanding insurance claims to be paid. Any unpaid claim amounts exceeding 45 days are transferred to your personal balance, and you will be responsible for payment at that time.

When using a third-party finance company (CareCredit, etc.) our office is charged a processing fee. As a courtesy to the patient, we do not pass this fee along to you. If for some reason treatment is not continued and/or completed and credit must be issued all fees charged will be applied to this credit before a refund is made.
I/We understand and agree that any credit granted shall be paid promptly in accordance with terms and agreements, that the credit grantor may add additional charges of $20-$40 in event of default to pay **reasonable collection charges,** court costs, and/or attorney fees.

Insurance

Our mission to our patients is to provide quality dental care. As a courtesy, our staff will file your insurance claim and assist in the collection from your insurance. However, DeSoto Family Dentistry does not render services on the assumption that our charges will be paid by the insurance company. ***The "Patient Portion" is only an estimate.*** In the event the insurance company pays less than the estimated amount, you are responsible for the unpaid balance. It is your insurance carrier that determines your benefits. Please understand that even if you have dental insurance, the financial liability for our services rests on you.

Appointments

Our patients are seen by appointment only. When an appointment is made, a treatment room is reserved specifically for that appointment. Arrival for any appointment 10 minutes late will require rescheduling. Our office will make a courtesy call at least 24 hours prior to your scheduled appointment time to confirm. Our policy is that we must speak to you or a legal guardian, personally, to secure your appointment time. **A $75 per scheduled hour cancellation fee for Hygiene and $150 per scheduled hour for treatment with Dr. will be applied to any missed or cancelled appointment without at least 24 hours' notice.**

Privacy Notice

By signing below, I acknowledge that I have been given the opportunity to review and receive a copy of this privacy notice & Financial Policy. I, also, am accepting for the payment of any charges in the treatment I receive by DeSoto Family Dentistry.

_____ _____

Patient Signature Date

If other than self, please print the name of the person signing this form and their relationship to the patient.

_____ _____

Name Relationship

_____ _____

Patient's Name Patient's DOB

HERE ARE SOME THINGS YOU SHOULD KNOW!

We, at DeSoto Family Dentistry believe that you deserve the best care. That is why we always present you with the best dental solution possible to treat your personal situation. Each year we provide OUTSTANDING dental care to all of our guests. Some have dental benefits, but most don't. If you have dental benefits, Congratulations! You are very fortunate. Here are some important things you should know…

***Due to the recent changes in insurance verification made by your insurance company, the following will now apply: Your insurance company no longer will provide us with waiting periods, frequencies, missing tooth clause, or down grades. If after 30 days your insurance has not paid the claim or denies it due to one of the reasons listed above the balance is your responsibility.

Your dental benefits are based upon a contract made between YOUR EMPLOYER and the INSURANCE COMPANY. If you have any questions regarding your dental benefits please contact your employer or your insurance carrier directly.

Dental benefits differ greatly from medical benefits. In 1959, most dental benefit plans had a yearly maximum cap of $1,000. You'll be surprised to know that presently, the average dental benefit plan has a yearly maximum cap of $1,000. That is $139.00 in "today's dollars". There has been no significant increase in the yearly maximum cap in over 40 YEARS! However, dental insurance premiums have risen over 600% in that same period of time. **DENTAL BENEFIT PLANS WILL NEVER PAY FOR THE COMPLETION OF YOUR DENTAL CARE. IT IS ONLY MEANT TO ASSIST YOU.**

Many people receive notification from their insurance company that dental fees are "above usual and customary". An insurance company determines their reimbursement (fee) level by surveying a geographical area (included in this are discounted dental clinics and managed care facilities, which have severely reduced dental fees by an additional 25%. So, an insurance company's "average, usual and customary" fee, by their own definition is much lower than the average! Any doctor in private practice will have fees that insurance companies define as "higher than usual and customary".

Many dental benefit plans deceptively tell their participants (YOU-the Patient) that they will cover "UP TO 80% or 100%" but do not clearly specify the plan fee schedule allowance, annual maximum or the limitations. It is more realistic to expect dental benefit plans to cover between 30%-60% of the dental services. **Remember that the amount a plan reimburses you is determined by how much your employer has paid for your dental benefit plan.** You will get back only what your employer has put in, less the insurance company's profit margin. If you are dissatisfied with this reimbursement, please speak with your personnel department / director, who can provide you with a proper, comprehensive dental benefit plan.

Insurance companies do NOT cover many routine, state of the art and/ or highly advance dental services.

Our team members will gladly assist you in filling the necessary forms to maximize your dental benefits and discuss your financial options. Excellent dental care is available WITH or WITHOUT dental benefits. We hope you will choose the best that dentistry has to offer.

Your insurance is a contract between YOU, YOUR EMPLOYER and the INSURANCE CARRIER**. We are NOT a party to that contract.** If you have a problem with your insurance coverage, we ask that you speak directly to your insurance company. YOUR CHARGES IN OUR OFFICE ARE YOUR RESPONSIBILTY FROM THE DATE THE SERVICES ARE RENDERED. We **DO NOT** base your diagnosed treatment on your insurance coverage. We base it on your needs and desires. We take pride in the quality of care we offer our patients and make every effort to have your dental visits with us be as comfortable as possible.

_____ _____

Patient Name (printed) Date

_____

Patient Signature

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Last Name:_____ **First Name:**_____
MI:_____

Patient record#:_____

Date of Birth:_____

By signing below, I am acknowledging that: I am either the patient or the patient's personal representative; I have received a copy of the "Notice of Privacy Practices" for **Desoto Family Dentistry**; and I understand that I may contact the person named in the Notice if I have questions about the content of the Notice.

Signature of patient or parent/legal guardian/legally responsible person:_____

Date:_____

Description of relationship to patient:_____

TO BE COMPLETED BY STAFF

Complete all applicable parts—Please refer to instructions

Part 1. Complete if signature requested but not obtained: Staff member sought but was unable to obtain an acknowledgment from the patient or the patient's personal representative for the following reason:

- Patient/personal representative refused to sign form
- Other

Part 2. Complete if patient/personal representative unavailable to sign form on first date of service delivery: D Form mailed/sent to patient/personal representative on _____.

Part 3. Complete if either Part 1 or Part 2 completed:

Signature of staff member:_____ Date_____