Summit dental group

New Patient Registration

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PATIENT INFORMATION

Name:_____ **Gender**: ☐ M ☐ F **DOB**:___/____/_____ **SS#**:_____

Preferred Name:_____ **Marital Status**: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

Address:_____ **City**:_____ **State**:_____ **Zip**:_____

Cell #:_____ **Home#**:_____ **Work#**:_____

Email: _____ **Employer**: _____

Physicians Name:_____ **Phone#**:_____

Emergency Contact:_____ **Phone #**:_____ **Relationship**:_____

☐ **It is OK to send appointment reminders by text?** ☐ **It is OK to send appointment reminders by email?**

If patient is under 18, provide guardian's name/ person responsible for account:_____

How did you hear about our office? ☐ Google ☐ Insurance_____ Other: _____ ☐ Website ☐ Referred by: _____

DENTAL INSURANCE

Dental Insurance? ☐ Y ☐ N Insurance Company:_____ID#:_____Grp#:_____

If not self, Policy Holder's Name: _____ DOB:___/____/_____ Employer:_____

I authorize release of any information relating to all dental claims and understand that I am responsible for all costs of dental treatment regardless of what insurance pays. I understand that all co-payments/deductibles are due at the time of treatment. I hereby authorize payment of dental benefits otherwise payable to me directly to Summit Dental Group

Patient/Guardian Signature: _____Date:___/____/_____

DENTAL HISTORY

Check any of the following problems that currently apply to you:

☐ Sensitivity (hot,cold,sweets)
☐ Tooth ache pain
☐ Broken teeth or broken fillings
☐ Bleeding, swollen, or sore gums

Have you ever been treated for gum disease? ☐ Y ☐ N

When was your last:

Cleaning?_____ X-Rays?_____

Previous Dentist:_____

Why did you leave? _____

Do you smoke or use chewing tobacco? ☐ Y ☐ N

How Much? _____For how long? _____

If I could change my smile, I would:

☐ Make them whiter
☐ Make them straighter or close spaces
☐ Replace missing teeth
☐ Replace old crowns that do not match

Questions/Concerns for the doctor?_____

_____

_____

HEALTH HISTORY

Please check any of the following that apply to you:

☐ AIDS/HIV	☐ Depression	☐ High Cholesterol	☐ Scarlet Fever
☐ Anemia	☐ Diabetes	☐ Immune Problems	☐ Seasonal Allergies
☐ Artificial Heart Valve	☐ Drug Addiction	☐ Kidney Disease	☐ Seizures
☐ Artificial Joints	☐ Emphysema	☐ Liver Disease	☐ Stomach Problems
☐ Asthma	☐ Excessive Bleeding	☐ Low Blood Pressure	☐ Stroke
☐ Blood Disease	☐ Glaucoma	☐ Mitral Valve Prolapse	☐ Thyroid Disease
☐ Bruise Easily	☐ Heart Condition/Surgery	☐ Osteoporosis	☐ Tuberculosis
☐ Cancer	☐ Heart Murmur	☐ Pacemaker	☐ Ulcers
☐ Chemotherapy/Radiation	☐ Hepatitis A,B, or C	☐ Respiratory Problems	☐
☐ Chest Pain/Angina	☐ High Blood Pressure	☐ Rheumatic Fever	Other_____
			_____

MEDICATIONS

Are you taking any medications? ☐ Y ☐ N

List of medications:_____

_____

_____

_____

_____

Are you or have you taken prescription medications for osteoporosis or bone cancer? ☐ Y ☐ N

Does your physician require you to be pre-medicated with antibiotics prior to dental treatment for any reason? ☐ Y ☐ N

WOMEN ONLY :

Are you taking oral contraceptives? ☐ Y ☐ N

If you are using oral contraceptives, it is important for you to know that antibiotics may interfere with your birth control's effectiveness. You will need to use mechanical forms of birth control for one complete cycle after you finish taking your antibiotics. Please consult with your physician for further guidance. **INTIALS**:_____

Are you pregnant or is there a chance you may be? ☐ Y ☐ N

Due Date:___/___/___

Are you nursing? ☐ Y ☐ N

Have you ever used Botox or Dermal Fillers? ☐ Y ☐ N

Would you be interested in Botox or Dermal Fillers? ☐ Y ☐ N

ALLERGIES

Mark any known allergies:

☐ Sulfa ☐ Latex ☐ Penicillin ☐ Local Anesthetic ☐ Other:_____

SLEEP /TMJ ASSESMENT

SLEEP	
Is it easy for you to fall asleep?	☐ Y ☐ N
Do you wake often during the night?	☐ Y ☐ N
Do you feel rested upon waking?	☐ Y ☐ N
Have you been told that you snore while sleeping?	☐ Y ☐ N
Has anyone ever seen you stop breathing while sleeping?	☐ Y ☐ N
Do you use or have you ever tried sleeping with a CPAP or APAP?	☐ Y ☐ N
TMJ	
Do you experience pain in your jaw and/or around your ears?	☐ Y ☐ N
Does your jaw make popping or clicking sounds when your jaw moves?	☐ Y ☐ N
Do you wake up with headaches in the morning or do headaches frequently develop in the evening?	☐ Y ☐ N
Do you grind your teeth at night?	☐ Y ☐ N
Are you prone to neck or shoulder pain?	☐ Y ☐ N

I understand that a thorough health history is important to assist the doctors in providing the safest care possible, and have answered all questions truthfully and to the best of my ability.

Patient/Guardian Signature:_____Date: ___/____/_____

Patient Printed Name:_____ Dentist Signature:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement.

I, _____ have received a copy of Summit Dental Group's Notice of Privacy Practices.

The following people have my permission to obtain information that is protected by the HIPAA Privacy Notice:

Name: _____Relationship:_____

Name: _____Relationship: _____

Name: _____Relationship:_____

Name: _____Relationship: _____

☐ ***I DO NOT ALLOW ANYONE ACCESS TO MY INFORMATION.***

Patient's Printed Name: _____

Patient/Guardian 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

☐ Communication barriers prohibited obtaining acknowledgement

☐ Other (Please specify) _____

Employee Signature: _____ Date:_____

WRITTEN FINANCIAL AND APPOINTMENT POLICIES

Thank you for choosing Summit Dental Group! Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options: Check, Cash, all Credit Cards or Care Credit (subject to credit approval). We also offer a 5% discount off of your co-pay if it is paid at the time that your appointment is scheduled. **NO DISCOUNTS OR PRE-PAYMENT COURTESIES OFFERED FOR PAYMENTS MADE WITH CARE CREDIT.**

For patients with dental insurance, we are happy to work with your carrier to maximize your benefits and directly bill them for reimbursement for your treatment. However, **all co-pays or estimated portions are due at the time of service.** If we receive more than is estimated from insurance, we will promptly issue a refund to you. **In the event that your insurance pays less than is estimated, the new balance due will be your responsibility.**

Any overdue balance not paid within 30 days will be subject to a finance charge of 1.5% monthly (18% annually). Any account with a patient balance over 90 days old may be turned over to a collection agency for collection and any fees charged by the agency and/or attorney's fees will be the patient's responsibility.

Summit Dental Group requires payment at the beginning of treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received. Summit Dental Group charges $25 for returned checks.

APPOINTMENT POLICIES:

In our office, we value the time appointed for all of our patients. Therefore, if you arrive more than 15 minutes late to your scheduled appointment, we reserve the right to reschedule your appointment out of respect to the next scheduled patient. Further, **all cancellations need to be made at least 24 hours in advance** or it will be considered a failed appointment. Failing two (2) appointments may result in a patient NOT being scheduled for any further treatment in our office.

Due to space limitations in the treatment rooms, we prefer children not to be accompanied by a parent/guardian unless special arrangements have been authorized. All other siblings MUST remain supervised in the waiting area until called for their appointment.

If you have any questions, please do not hesitate to ask. We are here to help you obtain the treatment that you want or need.

By signing below, I have read and understand the information presented, and all of my questions have been answered.

Patient/Guardian Signature: _____ Date: _____

Patient/Guardian Printed Name: _____