Patient Registration

Patient Name _____ (last) (first) (initial)

Male □ Female □
Single □ Married □ Separated □ Divorced □ Widowed □

Driver's License #_____

Address _____ City _____State _____Zip _____
Date of Birth _____Height _____Weight _____ Social Security # _____
Home Phone _____Business Phone _____ Cell Phone _____
E-mail address _____
Patient's Employer _____

Spouse's Name _____
Spouse's Employer _____
Spouse's work phone _____
Closest Relative not living with you _____Phone _____

Whom may we thank for referring you to us? _____

DENTAL INSURANCE COVERAGE

Name of Insurance Company _____
Employee Name _____

FINANCIAL POLICY

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

All patients must complete our "Patient Information Form" before seeing the doctor.
FULL PAYMENT IS DUE AT TIME OF SERVICE.
We accept cash, checks, Visa, Mastercard, America Express, Discover, debit cards and Care Credit.
We do not accept out of state checks.

ADULT PATIENTS OR MINORS ACCOMPANIED BY AN ADULT
Adult patients are responsible for full payment at time of service. The adult accompanying a minor, and his/her parents or guardians are responsible for full payment at time of service.

MISSED APPOINTMENTS
Unless cancelled at least 48 hours in advance, our policy is to charge a minimum of $25.00 for a missed appointment. Please help us serve you better by keeping scheduled appointments.

REGARDING INSURANCE
In our office we use only high tech materials and procedures without regard for your insurance company benefits. In other words, we will not compromise the quality of our dentistry.

INSURANCE POLICY

- Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. (We will inform you if we are a party to your insurance contract, and will handle your claims according to our agreement with the insurance company, if one exists.)
- We file insurance claims as a courtesy to our patients.
- We will not become involved in disputes between you and the insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, etc., other than to supply factual information as necessary.
- If you and/or your insurance company has not paid the FULL BALANCE within 60 days, late payment charges of 1.5% per month (minimum $3.00) will be added to your account. If your insurance company pays more than the balance due, we will send a refund check to you immediately.

AUTHORIZATION TO PAY BENEFITS TO DENTIST and RELEASE OF INFORMATION

I hereby authorize payment directly to Dr. Florian Braich, DDS, PA, of the benefits otherwise payable to me.
I authorize release to my insurance company of any information relating to my dental claims.
I understand that I am responsible for all charges for dental treatment.

Responsible Party Signature _____ Date _____

RETURNED CHECK POLICY

We reserve the right to charge our fee for a normal office visit for all returned checks. In the case of collection procedures we will add to your final bill all expenses generated by this action (such as collection agency fees, attorney fees, calls, mail, etc.).

DENTAL HISTORY

When was your last dental visit? _____
How often did you see your dentist? _____
Are you having any dental problems that require immediate attention?
_____
Do any of the following cause tooth discomfort? Hot _____ Cold _____ Sweets _____
Chewing _____
How often do you brush your teeth? _____Floss? _____Water Jet? _____
Do your gums bleed while cleaning? _____
Do your gums ever feel tender or swollen? _____
Have you ever had periodontal treatment? _____ When? _____
Do you clench or grind your teeth? _____ Do your jaws ever feel tired or ache? _____Click or Pop? _____
Can you chew on both sides of your mouth? _____ Comfortably? _____
Do you have frequent headaches? _____ Ear Aches? _____
Have you ever had orthodontic treatment (Braces)? _____ When? _____
Do you lose fillings or break fillings? _____ Do you usually have many cavities? _____
Do you have any loose teeth? _____ Cracked or Broken Teeth? _____ Food Traps? _____
Do you have any noticeable wear on your teeth? _____
Do you have any missing teeth? _____ Have they been replaced? _____

DENTAL HISTORY (cont.)

If so, how? Fixed Bridge _____ Removable Partial _____ Full Denture _____ Dental Implant _____

Are you comfortable with the replacement? _____
Please describe_____

How do you feel about the appearance of your smile?
_____
Have you ever had any cosmetic dentistry done to improve your appearance?
_____
If yes, are you pleased with the results? _____ Please comment
_____
Have you ever had an unpleasant dental experience?
_____

MEDICAL HISTORY

Name and address of primary care physician
_____

Have you been under a physician's care during the past 2 years? _____
For _____

Have you been treated in a hospital in the past 2 years? _____
For _____

Have you ever had major surgery? _____
For _____

If female: Are you taking hormones or birth control? _____

Are you pregnant or nursing? _____

Have you ever had a blood test for hepatitis? _____ Were you vaccinated? _____

Have you had canker or cold sores on your lips, tongue, gums or body?
_____

Are you now taking or have you taken any prescription drugs during the past year? _____
For _____

Are you allergic to: Penicillin □ Codeine □ Local Anesthetics □ Other □

Please Describe
_____

Have you had or do you now have:

	Yes	No		Yes	No		Yes	No
Acne			Fainting			Painful Menstruation		
AIDS			Glaucoma			Polio		
Abnormal Blood Pressure			Gynecological surgery			Prolonged Bleeding		
Allergies			Headaches			Prolonged Cough		
Anemia			Heart Disease			Psoriasis		
Angina			Heart Murmur			Psychiatric Treatment		
Arthritis			Hepatitis			Radiation Therapy		
Artificial Heart Valves			Herpes			Rheumatic Fever		
Artificial Joints			HIV			Rosacea		
Asthma			Jaw Pain			Sickle Cell Anemia		
Cancer			Jaundice			Seborrhea		
Chemotherapy			Kidney Disease			Shortness of Breath		
Congenital Heart Lesions			Liver Disease			Skin Cancer		
Contact Dermatitis			Lower Blood Pressure			Stroke		
Diabetes			Menopausal problems			Thyroid Disease		
Drug Dependency			Muscle/Joint Pain			Tuberculosis		
Earaches			Mycosis			Ulcers		
Eczema			Organ Transplant			Venereal Disease		
Epilepsy			Pacemaker			Vision Problems		

Have you any disease, condition or problem not previously listed? _____

<u>IMPORTANT NOTE:</u>

A) If diagnosed with gum disease in combination with one or more of the above diseases or conditions, not treating the gums is the worse neglect of your health by aggravating these diseases and compromising your immune system.

B) If you are still healthy, the untreated gums will substantially facilitate the onset of such diseases above.

C) Please connect us with your primary physician of record for coordinated care of your general health/rehabilitation of your immune system.

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

Signature _____ Date _____