BERRIEN DENTAL PATIENT REGISTRATION

FIRST NAME_____ **LAST NAME**_____ **MIDDLE INITIAL** ___

Preferred Name_____ Sex: ☐ Male ☐ Female Marital Status: ☐ S ☐ M ☐ D ☐ W

Birth Date_____ Soc. Sec_____ Drivers Lic_____

Address_____ Address 2 _____

(IF ADDRESS IS A P.O. BOX, PLEASE INCLUDE STREET ADDRESS AS ADDRESS 2)

City, State, Zip_____

Home Phone_____ Work Phone_____ Ext_____

Cell_____ Email address_____

Employer _____ Employer's telephone_____

Employer's address _____City_____State_____Zip_____

Emergency contact person, **NOT LIVING WITH YOU?** _____Phone_____

If patient is a student, please complete:

Name of School_____ Full Time ☐ Part Time ☐

RESPONSIBLE PARTY INFORMATION

FIRST NAME_____**LAST NAME**_____**Sex:** ☐ M ☐ F

Birth Date_____ Soc. Sec_____ _____Drivers Lic_____

Address_____ Address 2 _____

(IF ADDRESS IS A P.O. BOX, PLEASE INCLUDE STREET ADDRESS AS ADDRESS 2) Relationship to Patient_____

City, State, Zip_____

Home Phone_____Work Phone_____ Ext_____

Cell_____Email address_____

Employer _____ _____Employer's telephone_____

Employer's address _____City_____State_____Zip_____

SPOUSE_____ _____Work Phone_____ Ext_____

Birth Date_____Soc. Sec_____Relationship to Patient_____

Employer _____ _____ ____Employer's telephone_____

Employer's address _____City_____State_____Zip_____

DENTAL INSURANCE INFORMATION

Primary Insurance Co. _____Phone _____

Insurance Co. Address_____City_____State_____Zip_____

ID #_____ ___ Group # _____

Policy Holder's Name_____Birthdate_____Relationship to patient _____

Address_____City_____State_____Zip_____

Is Insurance through employer? _____If yes, list employer_____

Secondary Insurance Co._____Phone_____

Insurance Co. Address_____City_____State_____Zip_____

ID #_____ ___ Group # _____

Policy Holder's Name_____Birthdate_____Relationship to patient _____

Address_____City_____State_____Zip_____

Is Insurance through employer?_____If yes, list employer_____

BERRIEN DENTAL PATIENT DENTAL AND MEDICAL INFORMATION

Patient name: _____Date of birth: _____Age:_____ Sex:_____

DENTAL HEALTH HISTORY

Reason for Today's visit:_____ **Date of last visit**:_____

CHECK "YES" OR "NO" TO INDICATE IF YOU CURRENTLY HAVE OR HAVE HAD ANY OF THE FOLLOWING:

BAD BREATH	☐YES	☐NO	LOOSE TEETH OR BROKEN FILLINGS	☐YES	☐NO
BLEEDING GUMS	☐YES	☐NO	MOUTH BREATHING	☐YES	☐NO
BLISTERS ON LIPS OR MOUTH	☐YES	☐NO	ORTHODONTIC TREATMENT	☐YES	☐NO
BURNING SENSATION ON TONGUE	☐YES	☐NO	PAIN AROUND EAR	☐YES	☐NO
CHEWING TOBACCO	☐YES	☐NO	PERIODONTAL (GUM) TREATMENT	☐YES	☐NO
CIGARETTE, PIPE, OR CIGAR SMOKING	☐YES	☐NO	SENSITIVITY TO COLD	☐YES	☐NO
CLICKING OR POPPING JAW	☐YES	☐NO	SENSITIVITY TO HEAT	☐YES	☐NO
DRY MOUTH	☐YES	☐NO	SENSITIVITY TO SWEETS	☐YES	☐NO
FOOD COLLECTION BETWEEN THE TEETH	☐YES	☐NO	SENSITIVITY TO BITING	☐YES	☐NO
GRINDING TEETH	☐YES	☐NO	SORES OR GROWTHS IN MOUTH	☐YES	☐NO
GUMS SWOLLEN OR TENDER	☐YES	☐NO	MOUTH PAIN UPON BRUSHING	☐YES	☐NO
JAW PAIN OR TIREDNESS	☐YES	☐NO	DENTURES OR PARTIAL DENTURES MADE OVER 5 YEARS AGO	☐YES	☐NO
LIP OR CHEEK BITING	☐YES	☐NO			

HOW OFTEN DO YOU BRUSH? _____ **HOW OFTEN DO YOU FLOSS?** _____

MEDICAL HEALTH HISTORY

CHECK "YES" OR "NO" TO INDICATE IF YOU CURRENTLY HAVE OR HAVE HAD ANY OF THE FOLLOWING:

HEART PROBLEMS	☐YES	☐NO	BLOOD PROBLEMS	☐YES	☐NO
CHEST PAIN	☐YES	☐NO	EASY BRUISING	☐YES	☐NO
SHORTNESS OF BREATH	☐YES	☐NO	FREQUENT NOSEBLEEDS	☐YES	☐NO
BLOOD PRESSURE PROBLEM **(High/Low)**	☐YES	☐NO	ABNORMAL BLEEDING	☐YES	☐NO
HEART MURMUR	☐YES	☐NO	BLOOD DISEASE (ANEMIA)	☐YES	☐NO
HEART VALVE PROBLEM, (e.g. MVP)	☐YES	☐NO	EVER REQUIRE A BLOOD TRANSFUSION	☐YES	☐NO
SWELLING OF FEET AND ANKLES	☐YES	☐NO			
TAKING HEART MEDICATION	☐YES	☐NO	ALLERGY PROBLEMS	☐YES	☐NO
RHEUMATIC FEVER	☐YES	☐NO	HAY FEVER	☐YES	☐NO
PACEMAKER	☐YES	☐NO	SINUS PROBLEMS	☐YES	☐NO
ARTIFICIAL HEART VALVE	☐YES	☐NO	SKIN RASHES	☐YES	☐NO
CONGENITAL HEART LESIONS	☐YES	☐NO	TAKING ALLERGY MEDICATION	☐YES	☐NO
			ASTHMA	☐YES	☐NO
INTESTINAL PROBLEMS	☐YES	☐NO			
ULCERS	☐YES	☐NO	BONE OR JOINT PROBLEMS	☐YES	☐NO
UNEXPLAINED WEIGHT LOSS OR GAIN	☐YES	☐NO	ARTHRITIS/RHEUMATISM	☐YES	☐NO
SPECIAL DIET	☐YES	☐NO	BACK OR NECK PAIN	☐YES	☐NO
CONSTIPATION/DIARRHEA	☐YES	☐NO	JOINT REPLACEMENT (e.g., total hip, knee, pins, or implants)	☐YES	☐NO
KIDNEY OR BLADDER PROBLEMS	☐YES	☐NO			
KIDNEY DISEASE	☐YES	☐NO	**PREMEDICATION REQUIRED BY PHYSICIAN**	☐YES	☐NO
			TUBERCULOSIS OR RESPIRATORY DISEASE	☐YES	☐NO
FAINTING SPELLS, SEIZURES, OR EPILEPSY	☐YES	☐NO	EMPHYSEMA	☐YES	☐NO
STROKE(S)	☐YES	☐NO	DO YOU SMOKE?	☐YES	☐NO
FREQUENT OR SEVERE HEADACHES	☐YES	☐NO	If so, how much? _____		
HISTORY OF HEAD INJURY	☐YES	☐NO			
THYROID PROBLEMS	☐YES	☐NO	DO YOU CONSUME ALCOHOL?	☐YES	☐NO
			If so, how much? _____		
PERSISTENT COUGH OR SWOLLEN GLANDS	☐YES	☐NO			
TONSILLITIS	☐YES	☐NO	HISTORY OF ALCOHOL OR DRUG ABUSE?	☐YES	☐NO
CANCER/TUMOR	☐YES	☐NO	HEPATITIS (type _____?)	☐YES	☐NO
HISTORY OF CHEMOTHERAPY/RADIATION	☐YES	☐NO	JAUNDICE OR LIVER TROUBLE	☐YES	☐NO
			HERPES OR OTHER STD	☐YES	☐NO
DIABETES	☐YES	☐NO	HIV –positive/AIDS	☐YES	☐NO
URINATE MORE THAN 6 TIMES A DAY	☐YES	☐NO	GLAUCOMA	☐YES	☐NO
THIRSTY OR DRY MOUTH MUCH OF THE TIME	☐YES	☐NO	DO YOU WEAR CONTACT LENSES?	☐YES	☐NO
FAMILY HISTORY OF DIABETES	☐YES	☐NO	HISTORY OF MENTAL DISORDERS	☐YES	☐NO
PHYSICAL DISABILITIES	☐YES	☐NO			

CONTINUED ON OTHER SIDE

ARE YOU ALLERGIC, OR HAVE YOU REACTED ADVERSELY, TO ANY OF THE FOLLOWING?

LOCAL ANESTHETICS ("NOVACAINE")	☐YES	☐NO
PENICILLIN OR OTHER ANTIBIOTICS	☐YES	☐NO
SULFA DRUGS	☐YES	☐NO
ASPIRIN, ACETAMINOPHEN, OR IBUPROFEN	☐YES	☐NO
CODEINE, DEMEROL, OR OTHER NARCOTICS	☐YES	☐NO
BARBITURATES, SEDATIVES, SLEEPING PILLS	☐YES	☐NO
REACTION TO METALS	☐YES	☐NO
LATEX OR RUBBER DAM	☐YES	☐NO

OTHER _____

_____

DURING THE PAST 12 MONTHS, HAVE YOU TAKEN ANY OF FOLLOWING?

ANTIBIOTICS OR SULFA DRUGS	☐YES	☐NO
ANTICOAGULANTS (e.g., COUMADIN)	☐YES	☐NO
HIGH BLOOD PRESSURE MEDICINE	☐YES	☐NO
INSULIN, ORINASE, OR SIMILAR DRUG	☐YES	☐NO
ASPIRIN	☐YES	☐NO
NONPRESCRIPTION DRUG/SUPPLEMENTS	☐YES	☐NO
ORAL BISPHOSPHONATES, (e.g. Fosamax, Boniva, Actonel, Aredia, Reclast, Skelid, Zometa, etc.)	☐YES	☐NO

OTHER _____

_____

WOMEN:

ARE YOU TAKING CONTRACEPTIVES OR OTHER HORMONES?	☐YES	☐NO
ARE YOU PREGNANT?	☐YES	☐NO
If so, expected delivery date: _____		
ARE YOU NURSING?	☐YES	☐NO
HAVE YOU REACHED MENOPAUSE?	☐YES	☐NO
If so, do you have any symptoms? _ _____		

1)	DO YOU FEEL TIRED AFTER A FULL NIGHTS REST?	☐YES	☐NO
2)	DO YOU, OR HAS ANYONE TOLD YOU THAT YOU SNORE?	☐YES	☐NO
3)	HAVE YOU EVER WOKEN UP IN THE MIDDLE OF THE NIGHT CHOKING/GASPING FOR AIR?	☐YES	☐NO
4)	DO YOU WEAR, OR HAVE YOU BEEN PRESCRIBED A CPAP?	☐YES	☐NO

DO YOU HAVE ANY OTHER CONDITIONS NOT LISTED? ☐YES ☐NO

If so, explain:_____

_____

_____

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

_____

_____

_____

_____

_____ _____

SIGNATURE OF PATIENT/RESPONSIBLE PARTY **DATE**

REVIEWED BY: _____ _____

DATE

Berrien Dental Financial and Cancellation Protocol

DENTAL BENEFITS – Please provide your insurance card at the time of service. We ask that you inform us of any changes to your dental benefits, address, phone number, or employment status. If you do not have the required insurance information, we may ask that you pay in full at the time of service.

CO-PAYS, DEDUCTIBLES, & NON-COVERED SERVICES – All co-payments, deductibles and non-covered services are due at the time of service. We cannot waive co-pays or deductibles as this would be a breach of contract between you and your insurance carrier.

CLAIM SUBMISSION – We will submit dental claims to all insurance companies as a courtesy. We emphasize that as your dental provider, our relationship is with you, our patient, and not with your insurance company. Your dental benefit plan is a contract between you, your employer, and the insurance company. If a claim remains unprocessed after 60 days, we may ask you to contact your insurance carrier and/or pay the outstanding balance.

NON-PAYMENT – If you have an unpaid balance, you will receive one statement. Should it become necessary to send additional statements for an unpaid balance, you will be charged a monthly service fee of $5.00 and/or be subject to collection proceedings.

RETURNED CHECK – In the event that we receive a returned check due to insufficient funds, or a stop payment; a $35.00 fee will be assessed to your account.

FORMS OF PAYMENT – We accept **CASH, CHECK, MONEY ORDER, MASTERCARD, VISA, DISCOVER, & CARE CREDIT.**

CANCELLATION/NO SHOW POLICY –The office requires a minimum of **24 hours** notice if an appointment must be cancelled. Repeated broken appointments with less than a 24 hour notice will result in you being asked to pre pay any future appointments or being dismissed from the practice.

When patients give our office an advanced notice of their need to cancel a scheduled appointment, this time can then be allocated to patients in urgent need of treatment. In this way, the office can best serve the needs of ALL patients.

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I understand and agree that I will be financially responsible for services provided to me and all costs of collection incurred by the practice should my account be determined delinquent. I have provided the practice with all of my insurance information and will keep this office informed if my insurance coverage changes. I have read and understand the policies and how they affect me and my financial obligations to the practice.

RELEASE OF AUTHORIZATION –I authorize and direct payment by my insurance company to Berrien Dental. I understand and agree that I am responsible for all charges; regardless of any dental benefits.

_____ _____

Signature of Patient/Responsible Party **Date**

_____

Printed Name of Patient/Responsible Party