

Welcome to Dr. Peer's Office

New Patient Registration Form

Patient Name: Last First MI Preferred Name TODAY'S DATE

Title: Mr./Mrs./Ms./etc. Gender: Male Female Family Status: Married Single Child Other

Birth Date: Social Security # Previous Visit Date

Email Address: Best time to call:

Phone: Home Mobile (Cell) Work ext. Fax Other

Address:

How did you hear about us?

In an emergency who should be notified? Please enter Name(s) and Phone Number(s) below:

Employment Information

The following is for: the patient the person responsible for payment both not applicable

Employer Name: Employer Phone:

Employer Address:

Primary Dental Insurance

Name of Insured:
Last First MI TODAY's DATE

Insured's Birth Date: ID #: Group #:

Insured's Address:

Insured's Employer Name:

Employer's Address:

Patient's relationship to insured: Self Spouse Child Other

Insurance Plan Name:

Insurance Address:

Insurance Company Phone Number:

Insurance Authorization:

By checking this box,
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

 Patient Signature: _____ Date: _____

Consent for Services and Financial Policy

Financial arrangements must be made in advance as a condition of treatment by this office. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed. Patients with dental insurance understand that all dental services are charged directly to the patient and that he/she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms, assist in making collections from insurance companies, and will credit any collections to the patient's account. This dental office cannot render services on the assumption that our charges will be paid by an insurance company. A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. If after 60 days the bill has not been paid, we shall have the right to take any legal action needed to collect said bill through our collection agency. They shall have to the right to collect reasonable attorney fees equal to 25% of the total bill. I agree to pay the charges for the services at the time of treatment, or within 5 days of billing if credit is extended. I further agree that the charges for services shall be billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition, and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. I grant my permission to you or your assignee to telephone me to discuss this statement or my treatment.

By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the Administration Form.

➡ Patient Signature: _____ Date: _____

HIPPA Acknowledgement

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to: (1) provide/coordinate my treatment among health care providers who may be involved in that treatment directly/indirectly, (2) obtain payment from third-party payers for my health care services, and (3) conduct normal health care operations such as quality assessment and improvement activities. I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I understand that you are not required to agree to my requested restrictions, but, if you do agree, then you are bound to abide by such restrictions.

You may contact me at: (Please check all that apply)

- My home telephone number My mobile telephone number My work telephone number
 My email Other

Please list authorized persons with whom we may discuss your Protected Health Information (PHI) in addition to custodial parents and legal guardians:
(example: John Doe 212-555-1212)

By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPPA Disclosure Form.

➡ Patient Signature: _____ Date: _____

Name of person completing this form:

Relationship to the patient:

Response Date:

Dental Information

Last
First
MI

How would you rate the condition of your mouth?

- Excellent Good Fair Poor

TODAY'S DATE

Previous Dentist's Name and Phone Number:

Date of most recent dental exam and dental x-rays:

I routinely see my dentist every:

- 3 months 4 months 6 months 12 months Not routinely

What is your immediate concern?

Is there anything about the appearance of your smile that you would like to change?

Check all that apply:

- Had complications from past dental treatment
- Had trouble getting numb
- Had any reactions to local anesthetic
- Had/have braces, orthodontic treatment
- You experience dry mouth
- Any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth
- Food gets trapped between any teeth
- Have you ever whitened or bleached your teeth
- Have you experienced popping and/or clicking of your jaw joint
- You have difficulty chewing
- You clench or grind your teeth
- You wear or have worn a bite appliance
- Gums bleed when brushing or flossing
- Treated for gum disease or were told you have lost bone around your teeth
- Noticed an unpleasant taste or odor in your mouth
- Experienced gum recession
- Had any teeth become loose on their own (without injury)
- Experienced a burning sensation in your mouth
- You snore or wake up frequently during the night

If any of the checked boxes need further explanation, please describe:

Medical History:

Patient Name:

Last

First

MI

Preferred Name

TODAY'S DATE

Indicate which of the following conditions you have or have had. Checking the box will indicate a "YES" response. Leaving the box blank will indicate a "NO" response.

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Amoxicillin Allergy | <input type="checkbox"/> Anemia | <input type="checkbox"/> Angina |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Aspirin/Ibuprofen Allergy | <input type="checkbox"/> Asthma – Hay Fever |
| <input type="checkbox"/> Barbiturate Allergy | <input type="checkbox"/> Bee Sting Allergy | <input type="checkbox"/> Bleeds Excessively | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Cardiac Pacemaker | <input type="checkbox"/> Ceclor Allergy | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Cipro Allergy |
| <input type="checkbox"/> Clindamycin Allergy | <input type="checkbox"/> Codeine Allergy | <input type="checkbox"/> COPD | <input type="checkbox"/> Coumadin/Warfarin Allergy |
| <input type="checkbox"/> Darvocet Allergy | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Dialysis | <input type="checkbox"/> Doxycycline Allergy |
| <input type="checkbox"/> Drug Dependency | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Epilepsy - Seizures | <input type="checkbox"/> Erythromycin Allergy |
| <input type="checkbox"/> Fainting – Dizziness | <input type="checkbox"/> Food Allergy | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Head Injury |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Hepatitis - Jaundice | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> HIV - AIDS | <input type="checkbox"/> Iodine Allergy |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Latex Allergy | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Mental Illness | <input type="checkbox"/> –Mycin allergy | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Organ transplant |
| <input type="checkbox"/> Penicillin Allergy | <input type="checkbox"/> Polio | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Pre-med |
| <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Respiratory Issues | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Sedative Allergy |
| <input type="checkbox"/> Sexually Trans. Disease | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Sulfa Allergy | <input type="checkbox"/> Swollen Ankles | <input type="checkbox"/> Tetracycline Allergy | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Tumors | <input type="checkbox"/> Ulcers | |

- Local anesthetics allergy *Carbocaine, Lidocaine, Marcaine, Novocaine, Septocaine*
- Rubber products allergy
- Presently being treated for any other illness
- Taking medication for weight control (*ie fen-phen*)
- Taking dietary supplements
- Subject to frequent headaches
- A smoker or smoked previously
- Drink alcohol regularly

Other allergies that are not listed above:

If any conditions or alerts selected above need further clarification, please describe below, indicating serious illnesses, operations, or hospitalizations:

Have you had open heart or heart valve replacement surgery? If so, please describe below. Please include any complications from procedure:

Have you had an orthopedic total joint replacement (hip, knee, elbow, finger)? Please describe below. Please include any complications from procedure:

Have you ever been told by a physician or dentist that you need to be pre-medicated by an antibiotic before your dental visits? If yes, please explain.

What is your estimate of your general health? Excellent Good Fair Poor

Name of your physician and date of your last physical:

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

List all medications, drugs, pills or herbal remedies, regular dosages of aspirin, and non-prescription medications. Please include the problem for which each is taken.

Name of the pharmacy where you have your prescriptions filled:

By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have been excluded. I am aware that I must notify the practice of any future changes. This will serve as my electronic signature.

 Patient Signature: _____

Date: _____

FEMALES
ONLY:

- | | |
|---|--|
| <input type="checkbox"/> Taking contraceptives (birth control) | <input type="checkbox"/> Using Hormone Replacement Therapy |
| <input type="checkbox"/> Currently pregnant or planning pregnancy | <input type="checkbox"/> Nursing |