PATIENT REGISTRATION FORM

OFFICE USE ONLY
Processed by: _____

Patient Information

PATIENT'S NAME *as it appears on insurance or ID* (FIRST, LAST, MIDDLE)					PREFERRED NAME	☐ Mr ☐ Miss ☐ Ms ☐ Mrs
SEX	MARITAL STATUS	DATE OF BIRTH	AGE	SOCIAL SECURITY NUMBER	PICTURE ID ☐DL ☐Mil ☐Other	PATIENT IS: ☐ Policy Holder ☐ Responsible Party
PATIENT'S ADDRESS		CITY	STATE	ZIP		HOME PHONE
CELLULAR PHONE	PAGER	E-MAIL ADDRESS				I would like to receive APPOINTMENT REMINDERS via: ☐E-mail ☐Text

Patient Employer / School Information

EMPLOYER / SCHOOL	OCCUPATION	PHONE NUMBER (+ EXTENSION)	EMPLOYER / SCHOOL ADDRESS

Emergency Contact Information

NAME OF EMERGENCY CONTACT #1	RELATION TO PATIENT	HOME PHONE	WORK PHONE	CELL PHONE
NAME OF EMERGENCY CONTACT #2	RELATION TO PATIENT	HOME PHONE	WORK PHONE	CELL PHONE

Billing and Insurance

Primary Health Insurance

INSURANCE COMPANY	EMPLOYER NAME	ID NUMBER	GROUP NUMBER	REMAINING MAX _____ REMAINING DED _____
INSURANCE CLAIMS ADDRESS	CITY	STATE	ZIP	CLAIMS PHONE NUMBER / PLAN NAME
NAME OF POLICY HOLDER / SUBSCRIBER (as it appears on insurance card or ID)	BIRTHDATE	SOCIAL SECURITY NUMBER	PICTURE ID (Type & Number)	
POLICY HOLDER'S ADDRESS	CITY	STATE ZIP	POLICY HOLDER PHONE	RELATIONSHIP

Secondary Health Insurance (if applicable)

INSURANCE COMPANY	EMPLOYER NAME	ID NUMBER	GROUP NUMBER	REMAINING MAX _____ REMAINING DED _____
INSURANCE CLAIMS ADDRESS	CITY	STATE	ZIP	CLAIMS PHONE NUMBER / PLAN NAME
NAME OF POLICY HOLDER / SUBSCRIBER (as it appears on insurance card or ID)	BIRTHDATE	SOCIAL SECURITY NUMBER	PICTURE ID (Type & Number)	
POLICY HOLDER'S ADDRESS	CITY	STATE ZIP	POLICY HOLDER PHONE	RELATIONSHIP

Responsible Party 1 (IF OTHER THAN PATIENT – for example: mother, father, grandparent, etc…)

NAME OF RESPONSIBLE PARTY / BILLING	RELATIONSHIP	BIRTHDATE	SOCIAL SECURITY NUMBER	PICTURE ID (Type & Number)
RESPONSIBLE PARTY ADDRESS	CITY	STATE	ZIP	PHONE NUMBER

Responsible Party 2 (IF OTHER THAN PATIENT – for example: mother, father, grandparent, etc…)

NAME OF RESPONSIBLE PARTY / BILLING	RELATIONSHIP	BIRTHDATE	SOCIAL SECURITY NUMBER	PICTURE ID (Type & Number)
RESPONSIBLE PARTY ADDRESS	CITY	STATE	ZIP	PHONE NUMBER

Assignment and Release for Fees and Payments

I, _____ (the undersigned), certify that I (or my dependent) have insurance coverage, and assign directly to Dr. Madrid and Associates all insurance benefits otherwise payable to me for services rendered. 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. I understand that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is my responsibility to pay any deductible amount, co-insurance, and any other charges or balance not paid for by my insurance company.** I also understand that if I fail to pay as promised, I will be responsible for all collection costs and legal fees (attorney, court…) incurred by the office in order to recover payment from me. I further understand that it is my responsibility to inform this office of any changes in my insurance coverage.

_____ _____ _____

PRINTED NAME of Patient, Parent or Legal Guardian | SIGNATURE of Patient, Parent or Legal Guardian | DATE

CONFIDENTIAL HEALTH HISTORY

OFFICE USE ONLY
Patient ID: _____
Processed by: _____

Patient Name:_____ Weight: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an interrelationship with the dentistry you will receive. Thank you for taking the time to answer all questions.

I. DENTAL INFORMATION (Please leave Blank if you do not understand the question)

1. Do you have, or have you ever had, any of the following?
   ☐ Difficulty Opening Mouth ☐ Clicking/Popping of the Jaw ☐ Grinding Teeth ☐ Nasal Obstruction
   ☐ Pain in Jaw Joints ☐ TMJ Problems ☐ Loud Snoring ☐ Wear dentures/partials
2. Have you had abnormal bleeding associated with previous extractions, surgery or trauma? ☐ Yes ☐ No
   If yes, please describe _____
3. Have you ever had any serious trouble associated with previous dental or surgical treatment? ☐ Yes ☐ No
   If yes, please describe _____
4. Have you had surgery or x-ray treatment for a tumor, growth or other mouth/lips condition? ☐ Yes ☐ No
   If yes, please explain _____

II. MEDICATIONS & ALLERGIES (Please leave Blank if you do not understand the question)

1. Do you use recreational, controlled or IV drugs (marijuana, cocaine, Phen-Fen…)? ☐ Yes ☐ No
   If yes, please list all, as they can be dangerous in conjunction with anesthetic drugs. _____
2. Do you take, or have you taken, any of the following?
   ☐ Antibiotics or Sulfa Drugs ☐ Digitalis or drugs for heart trouble ☐ Nitroglycerin
   ☐ Blood thinners (Coumadin, Aspirin, Advil) ☐ Insulin, Tolbutamide (Orinase) ☐ Pain killers (including Aspirin)
   ☐ Cortisone (Steroids), ACTH ☐ Medicine for high blood pressure ☐ Redux (now, or in the past)
   ☐ Medication containing Biphosphonates, or for Osteoporosis or Paget's Disease (Lendronate/Fosamax, Risedronate/Actonel, Aredia, Zometa)
   ☐ Tranquilizers ☐ Other _____
3. Are you allergic or have you reacted adversely to any of the following?
   ☐ Aspirin ☐ Iodine ☐ Sulfa Drugs ☐ Penicillin or other antibiotics ☐ Barbiturates, sedatives, or sleeping pills
   ☐ Latex ☐ Metal ☐ Local Anesthetics ☐ Other _____

III. MEDICAL HISTORY (Please leave Blank if you do not understand the question)

1. Do you have, or have you ever had…
   ☐ AIDS / HIV ☐ Fainting Spells, seizures ☐ Low blood pressure
   ☐ Asthma, emphysema, other lung diseases ☐ Hay Fever ☐ Persistent cough, coughing up blood
   ☐ Blood disorder such as Anemia ☐ Heart defects or congenital heart lesions ☐ Serious head or neck injury
   ☐ Blood transfusions ☐ Heart murmurs/mitral valve prolapse ☐ Shortness of breath after mild exercise
   ☐ Bleeding problems or bruise easily ☐ Hepatitis, jaundice, or liver disease ☐ Stomach ulcers & other problems
   ☐ Chest pain upon exertion ☐ Kidney, bladder disease ☐ Tuberculoses (TB)
   ☐ Diabetes ☐ Implants and/or prosthesis (artificial joints, elbow pins, etc.) ☐ Rheumatic fever or rheumatic heart disease
   ☐ Arthritis, inflammatory rheumatism (swollen joints, joint pain, stiffness) ☐ Venereal Disease (syphilis, gonorrhea…)
   ☐ Cardiovascular disease (arteriosclerosis, coronary occlusion, stroke, hardening of arteries, high blood pressure, heart trouble, heart attack…
2. Other _____

IV. WOMEN ONLY

1. Are you… ☐ Pregnant ☐ May be pregnant ☐ Trying to get pregnant ☐ Nursing ☐ Taking Oral Contraceptives*
   *Antibiotics and pain medication can stop absorption of birth control pills. Use another method of contraception for the remainder of that menstrual cycle.

IV. OTHER

1. Do you… ☐ use tobacco ☐ drink alcoholic beverages ☐ diet _____
2. Comments: _____

I certify that I have read and understood the questions above, and have answered every question completely and accurately to the best of my knowledge. I will not hold my doctor, or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form. I understand that it is my responsibility to inform my dentist of any change in my health and/or medication.

Name of Patient, Parent or Guardian	Relationship	Signature	Date	Doctor	Date

Updates:

Name of Patient, Parent or Guardian	Relationship	Signature	Date	Doctor	Date

ACKNOWLEDGEMENT OF RECEIPT OF PRISTINE DENTAL'S NOTICE OF PRIVACY PRACTICES & DENTAL MATERIALS FACT SHEET

RECIBO DE "NOTIFICACIÓN DE PRÁCTICAS DE PRIVACIDAD" Y "DATOS SOBRE LOS EMPASTES"

_____

Patient Name (Print) Firma del Paciente (Imprimir)

By signing this document, I acknowledge that I have received a copy of the:
Al firmar este documento, you reconozco haber recibido una copia del:

- ✓ Notice of Privacy Practices (Notificación de Practicas de Privacidad)
- ✓ Dental Materials Fact Sheet (Datos Sobre Los Empastes)

_____	_____	_____
Name of Patient, Parent or Legal Guardian	Signature	Date
Nombre del Paciente, Padre o Tutor Legal	Firma	Fecha

_____

Relationship to Patient (*If signed by a Personal Representative, please describe the representative's authority to act for the patient)*

Relación con el paciente (si está firmado por un representante personal, por favor describa la autoridad del representante para actuar en nombre del paciente)

FOR OFFICE USE ONLY (PARA USO DE LA OFICINA)

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices and Dental Materials Fact Sheet, but acknowledgement could not be obtained because:
Se intentó obtener reconocimiento escrito del recibo de nuestro Aviso de Prácticas de Privacidad y Materiales Dentales Hoja de Datos, pero no se pudo obtener la confirmación porque:

- ☐ Individual refused to sign (Individual negó a firmar)
- ☐ Communication barriers prohibited obtaining acknowledgement
  Las barreras de comunicación prohibieron obtener reconocimiento
- ☐ An emergency situation prevented us from obtaining acknowledgement
  Una situación de emergencia nos impidió obtener la confirmación
- ☐ Other (otro)_____

INFORMATION TO OUR PATIENTS

Our mission is to deliver the finest, most cost effective dental care available today. Following diagnosis our doctor will discuss with you our plan for treatment. We will also discuss the cost of today's and future treatments. Payments for all services are due at time of treatment. Because your dental plan may not cover the entire cost of your treatment, we offer several alternative payment options as listed below for your convenience.

Payment Options

1. Cash or Check
2. Visa, MasterCard, Discover or American Express
3. Monthly payment plans by third party (Care Credit, Citi Health, Icare...) – The monthly payment plan is a separate line of credit for dental care only. It does not require payment now, nor the use of your bank credit cards, leaving them free for non-healthcare purchases and emergencies. It does not affect the balance of your other credit cards, and there are no annual fees. Please let the front desk know if you are interested in this option. We would be happy to help.

Please indicate below the payment option(s) you wish. Don't worry – this is NOT an authorization to charge you. It is just to help us inform you of any available discounts associated with your preferred payment method. You can change it at any time.

☐ **Cash or Check**

☐ **Credit Card**

☐ **Monthly Payment Plan** – If you choose this option, we will help you complete the simple application. Processing usually takes just a few minutes.

OUR CANCELLATION / RESCHEDULING POLICY

When a patient makes an appointment, we reserve a significant amount of time specifically for that patient and, in some cases, spend a good amount of time preparing for that patient's scheduled service(s) prior to their arrival. So when that patient doesn't show for their scheduled appointment, it impacts not only the office's daily schedule, but also the office's efficiency *and* other patients who could have benefited from that time slot.

Therefore, **out of respect for our office and other patients, we ask that you give us at least 48 hours advanced notice should you need to cancel or reschedule an appointment**. *Preferably more than 48 hours prior to your scheduled time, but no less than 24.* **Failure to cancel or reschedule an appointment at least 24 hours before your appointment time will result in a cancellation fee of $25.**

In cases of extraordinary circumstances that do not allow a 24 hours notice, we will make limited exceptions for certain verifiable emergencies. In these situations, we appreciate being informed about the missed appointment as soon as possible. We also appreciate notification if patient is running late.

Thank you for your understanding and cooperation.

By signing below I, _____, acknowledge on behalf of _____ that I fully understand and agree to abide by Pristine Dental Group's cancellation/rescheduling policy as described above. I also understand that payments for services not covered under my insurance are due at the time of treatment. I further understand that, if for some reasons my insurance does not pay for any treatments/services rendered, I am responsible for the remaining balance.

Signature of Patient / Responsible Party	Relationship	Date