Paris Family Dental

524 E Madison St – Paris, IL 61944 – (217) 463-4110

PATIENT REGISTRATION

Date_____

Patient Information: (CONFIDENTIAL)

Name_____MI_____ Birthdate_____ SS#_____
Address_____City_____State_____Zip_____
Email_____ Home Ph_____ Cell Ph_____
Check Appropriate Box: □ Minor □ Single □ Married □Divorced □Widowed □ Separated
Person to contact in case of emergency?_____Relationship_____ Phone _____

Responsible Party:

Person responsible for account_____Relationship_____
Address_____City_____State_____Zip_____
Email_____Cell Ph_____Home Ph_____
Birthdate_____ Work Phone_____ SS#_____
Is this person currently a patient in our office? □ Yes □ No

How did you hear about our office?

DENTAL INSURANCE INFORMATION (Primary Carrier)	**If you have another insurance coverage, complete this for 2nd coverage**
Insured's name	**Insured's name**
Insured's employer	**Insured's employer**
Insurance Co	**Insurance Co**
Insurance Co Address	**Insurance Co Address**
Phone # **DOB**	**Phone #** **DOB**
SS#	**SS#**
Group # **Local #**	**Group #** **Local #**

FINANCIAL POLICY

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment. Please note that payment of your bill is considered part of your treatment. Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa and Discover. Outside financing is available upon request and approval.

Please check if you would like more information about financing options. ☐

Please note: Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance, you will be responsible for any collection and/or legal charges up to 40%.

Do You Have Insurance?

- As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid. We will, of course, do all we can to make sure your estimate is a s accurate as possible.
- All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Our office is not a party to that contract.
- Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.
- We ask that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance company, by cash, check, MasterCard, Visa, or Discover at the time we provide the service to you.

Consent:

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO MY DENTAL OFFICE. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge and/or attorney fee will be added to any overdue balance.

Patient Signature (Parent if child)_____ **Date**_____

Patient's Name: _____

DENTAL/MEDICAL HISTORY

Are you under a physician's care? What for?_____ Family Physician _____ Phone Number _____
_____

What medications are you currently taking?_____ Women: Are you pregnant? Y N
_____ Are you nursing? Y N Oral Contraceptives? Y N

Are you on a special diet? Y N Do you use tobacco? How much per day/week? _____ Do you use controlled substances? Y N

Do you drink alcohol? How much per day/week? _____ Have you ever taken Phen-Fen or Redux? Y N Have you had a serious neck injury? Y N

Do you have difficulty opening your mouth? Y N Do you clench or grind your teeth? Y N

Have you had difficulty with dental extractions, prolonged bleeding post-operatively in the past? Y N

Have you ever been advised by a physician to take a pre-medication before any dental appointments? Y N

Would you like to discuss cosmetic smile enhancement? Y N

Please circle items below if you have or have had any of the following:

AIDS/HIV Positive	Cortisone Medicine	Hemophilia	Radiation Treatments
Alzheimer's Disease	Diabetes	Hepatitis A	Recent Weight Loss
Anaphylaxis	Drug Addiction	Hepatitis B OR C	Renal Dialysis
Anemia	Easily Winded	Herpes	Rheumatic Fever
Angina	Emphysema	High Blood Pressure	Rheumatism
Arthritis/Gout	Epilepsy/Seizures	High Cholesterol	Scarlet Fever
Artificial Heart Valve	Excessive Bleeding	Hives/Rash	Shingles
Artificial Joint	Excessive Thirst	Hypoglycemia	Sickle Cell Disease
Asthma	Fainting/Dizziness	Irregular Heartbeat	Sinus Trouble
Blood Disease	Frequent Cough	Kidney Problems	Spina Bifida
Blood Transfusion	Frequent Diarrhea	Leukemia	Stomach/Intestinal Disease
Breathing Problems	Frequent Headaches	Liver Disease	Stroke
Bruise Easily	Genital Herpes	Low Blood Pressure	Swelling of Limbs
Cancer	Glaucoma	Lung Disease	Thyroid Disease
Chemotherapy	Hay Fever	Mitral Valve Prolapse	Tonsillitis
Chest Pains	Heart Attack/Failure	Osteoporosis	Tuberculosis
Cold Sores/Fever Blisters	Heart Murmur	Pain in Jaw Joints	Tumors or Growths
Congenital Heart Disorder	Heart Pace Maker	Parathyroid Disease	Ulcers
Convulsions	Heart Trouble/Disease	Psychiatric Care	Venereal Disease

Other: _____

Are you allergic or have you reacted adversely to any of the following medications:

Aspirin	Codeine	Sedatives	Local Anesthetics
Iodine	Penicillin	Sulfa Drugs	Erythromycin
Tetracycline	Any Metals (Nickel, Mercury)	Barbiturates	Latex Rubber

Other: _____

Have you ever taken any of the following medications:

Actonel	Aredia	Boniva	Fosamax
Zometa	Reclast	Herbal Suppletments	

Consent:
The undersigned herby authorizes Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read, understand and agree to the above terms and conditions.

_____ _____ _____

Patient Signature **Date** **Dentist Signature**

{Paris Family Dental}

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

Authorization to Release Information

Purpose: This form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself.

I, _____, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

_____ _____
{Please Print Name} Relationship

_____ _____
{Please Print Name} Relationship

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
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

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