Patient Registration Form

BROOKS FAMILY DENTAL

Patient Name: _____ Date: _____

Gender: _____ Marital Status (please circle): Minor Single Married Widowed

Social Security #: _____ Birth Date: _____ Email: _____

Phone (Home): _____ Work: _____ Cell: _____

Address: _____ Apartment#:_____

City: _____ State: _____ Zip code: _____ Employer Name: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Is it okay to text you regarding any appointments or patient information? (Please circle): Yes No

Is it okay to text you regarding any statements or outstanding balance? (Please circle): Yes No

Date of Last Dental Visit: _____Previous Dentist:_____

Dental History, please check all that apply:

- ☐ Pain in any area of your mouth or teeth
- ☐ Dissatisfied with the appearance of your teeth
- ☐ Worried or apprehensive about coming to the dentist
- ☐ Problems with any previous dental treatment
- ☐ Experienced an unfavorable reaction to local anesthetic (Xylocaine, Novocain, etc)?

Have you been told you have a gum or bone problem? Clarify: _____

Have you lost many adult teeth? Clarify: _____

Have you experienced any of the following?:

- ☐ Frequently bleeding gums
- ☐ Food catching between teeth
- ☐ Burning tongue or mouth
- ☐ Frequent bad breath
- ☐ Extraction complications
- ☐ Swelling or lumps in mouth
- ☐ Clenching or grinding teeth
- ☐ Perio treatment
- ☐ Unpleasant taste
- ☐ Muscle soreness in face/neck
- ☐ Jaw popping or clicking
- ☐ Ortho treatments
- ☐ Teeth sensitivity to hot/cold
- ☐ Injury to face or jaw
- ☐ Frequent headaches

What dental aids do you use to clean your teeth? :_____

Whom may we thank for referring you to our practice?

- ☐ Another patient (Please list): _____
- ☐ Another Dental Office (Please list): _____
- ☐ Website
- ☐ Social Media
- ☐ Other: _____

FINANCIAL INFORMATION:

The following is for (please circle): The patient The person responsible for payment

Name: _____ Gender:_____ Date of Birth: _____

Social Security Number: _____ Address: _____
(City) (State) (Zip Code)

INSURANCE INFORMATION: *Please only complete if you have Dental Insurance*

Primary Insurance Co:	Secondary Insurance Co:
Insured Name:	Insured Name:
Insured DOB:	Insurance DOB:
Insured SSN:	Insured SSN:
Insurance Co Address:	Insurance Co Address:
Insurance Phone Number:	Insurance Phone Number:
Group#:	Group#:

CONSENT FOR SERVICES

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager.
- If you have dental insurance, we must emphasize that as your dental provider, our relationship is with you and not your dental insurance company. Your insurance policy is a contract between you, your employer and your insurance company. If there is any remaining balance owed after your insurance company has paid their portion, it will be the patient's responsibility, or responsible party on behalf of the patient, to pay the remaining balance in full.
- If your account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for any and all legal fees, collection agency fees, interest charges and any other expenses incurred in addition to the principal amount due.
- All emergency dental services, or any dental services performed without a previous financial arrangement, must be paid at the time that services are rendered.
- I authorize the staff of Brooks Family Dental, PC to perform any necessary services needed during diagnosis and treatment. I understand that services can change in the middle of a procedure at the dental providers discretion and I am responsible for any change in expenses at the time services are rendered.
- I grant my permission to you or your assignee, to call me at home, cell or work or text to discuss matters related to this form.
- To the best of my knowledge, all of the preceding answers and information are true and correct. If I ever have a change in my demographic information, health or financial information, I will inform the office at the next appointment.

APPOINTMENT POLICY:

At Brooks Family Dental, we put our faith in you to keep your appointment. When we set up an appointment, a specific amount of time is reserved especially for you. If for any reason you must cancel or change your appointment, it is important that you give our office ***at least 48 hours notice*** to offer that time to someone else.

- **Cancelled appointments** within the 48 hour window will require a phone call by you to let us know that the appointment will be cancelled. Same day cancellations will be considered a missed appointment.
- **Missed appointments** will be documented in your dental record.
    - Non-Insured patients: If you miss 1 or more dental appointments within a six-month-period, you must pay for the next appointment in full. If you miss the rescheduled appointment again, $25 will be applied as a non-refundable deposit.
    - Insured patients: If you miss 1 or more dental appointments within a six-month-period, you must pay a refundable deposit of $25 that cannot be billed to your insurance company. If you miss the rescheduled appointment, the $25 deposit will not be refunded to you.
- **Late arrivals:** If you arrive more than 15 minutes late for your appointment, you will be rescheduled to another date and time as to make sure that our Providers are given enough time to complete your treatment.

We will always try to confirm your appointments by text message, email or phone call. Please let us know as soon as possible if your schedule does not permit you arriving on time to your scheduled appointment. Exceptions will be made on a case by case basis, however, that cannot be done unless you have properly communicated that to our Front Desk Team.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of Patient

_____ Date: _____ Relationship to Patient: _____
Signature of Parent/Financial Guarantor