



PRECISION DENTAL
GENERAL & COSMETIC DENTISTRY

Adult Dental Registration & Treatment

Patient Information

Patient Name _____

Date of Birth _____ Male Female

Social Security # _____

Address _____

Phone:

Home _____ Work _____

Cell Phone _____

E-mail _____

May we use your email and/or mobile number to send appointment reminders, confirm your appointments or other information regarding your dental care?

Yes No

Employer/School _____

Primary Dental Insurance

Subscriber Name _____

Relationship to Patient _____

Date of Birth _____ SS/ID# _____

Address (if different from patient) _____

Subscriber's Employer _____

Insurance Company _____

Group # _____

Secondary Dental Insurance

Subscriber Name _____

Relationship to Patient _____

Date of Birth _____ SS/ID# _____

Address (if different from patient) _____

Subscriber's Employer _____

Insurance Company _____ Group # _____

Emergency Contact

Name _____

Relationship to Patient _____

Home phone _____ Cell Phone _____

How did you hear about Precision Dental?

Referral (Their Name) _____

Mailing Social Media (Facebook, Instagram etc...)

Building Sign Insurance Company

Web site Online Review (Yelp, Google, Demand Force)

Other _____

Cosmetic and Special Services

Are you interested in a FREE consultation or information on any of the following services?

Invisalign Teeth Straightening or Short Term Braces

Lumineers/Veneers

One hour in office instant teeth whitening

Dental Implants

Other _____

Assignment and Release

I certify that I, and/or my dependant(s), have insurance coverage with _____ and assign directly to Precision Dental
(Name of Insurance Company)

and it's associates all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Precision Dental and its associates may use my health care information and may disclose such information to the above named company and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

Signature of Patient or personal representative _____

Print name of Patient or personal representative _____

Relationship to Patient _____

Date _____



PRECISION DENTAL
GENERAL & COSMETIC DENTISTRY

Dental & Medical History Information

Dental History

Patient Name Reason for today's visit

Former Dentist City/State

Date of last dental visit Date of last dental X-rays How often do you brush? Floss?

Please check all dental conditions that apply, past or present:

- Bad Breath, Bleeding gums, Blisters on lips or mouth, Burning sensation on tongue, Chew on one side of mouth, Cigarette/pipe/cigar smoking, Clicking or popping jaw, Dry mouth, Fingernail biting, Food collection between teeth, Foreign objects, Grinding teeth, Gums swollen or tender, Jaw pain, Jaw tiredness, Lip or cheek biting, Loose teeth/broken filling(s), Mouth breathing, Mouth pain, brushing, Orthodontic treatment, Pain around ear, Periodontal treatment, Sensitivity to cold, Sensitivity to heat, Sensitivity to sweets, Sensitivity when biting, Sores/growths in mouth

Medical History

Physician's Name City/Phone# Date of last visit

Please check all that apply:

- AIDS/HIV, Anemia, Arthritis, Rheumatism, Artificial Joints, Asthma, Use Inhaler: Yes No, Blood Disease, Cancer, Type, Chemical Dependency, Chemotherapy, when, Circulatory Problems, Congenital Heart Lesions, Cortisone Treatments, Cough, persistent/bloody, Diabetes, Dizziness, Emphysema, Epilepsy/Seizures, Excessive Bleeding, Fainting, Glaucoma, Headaches, Heart Murmur, Heart Problems, Hepatitis, type, Herpes, High Blood Pressure, Jaundice, Jaw Pain, Kidney Disease, Liver Disease, Low Blood Pressure, Nervous Problems, Pacemaker, Psychiatric Care, Weight Loss/Gain, Radiation Therapy, when, Respiratory Disease, Rheumatic Fever, Scarlet Fever, Shortness of breath, Sinus Trouble, Skin Rash, Special Diet, Stroke, Swollen Feet/Ankles, Thyroid Problems, Tonsillitis, Tuberculosis, Tumor on Head/Neck, Ulcer, Venereal Disease, Other

Have you ever taken a medication that contains bisphosphonates? This includes brands such as Actonel, Aredia, Boniva, Didronel, Fosamax, Zometa. Yes No

Do you wear contact lenses? Yes No Are you taking birth control pills? Yes No

Are you pregnant? Yes No Are you nursing? Yes No

Medications (List any medications you are currently taking and the correlating diagnosis):

Allergies (Please check all that apply):

- Aspirin, Codeine, Erythromycin, Latex, Local Anesthetic, Metals, Penicillin, Sulfa, Tetracycline, Other

I certify to the accuracy of the above statements regarding my medical and dental history

Signature of patient, parent guardian or representative

Print name of patient, parent guardian or representative

Date



PRECISION DENTAL
GENERAL & COSMETIC DENTISTRY

Acknowledgement of Receipt of Notice of Privacy Practices

****You May Refuse to Sign This Acknowledgment****

If the patient is under 18 years of age, a parent or legal guardian must sign.

I, _____, have received a copy of this office's Notice of Privacy Practices.
{Please Print Patients Name}

{Signature of Patient or Parent/Legal Guardian}

{Date}

For Patients who need pre-medication only:

I am authorizing this office to call me and remind me to take my pre-medication before my dental appointment. They may leave a message for me regarding this information at any number that I have supplied to them. They may leave a message on any answering machine, voice mailbox or with whoever answers the telephone. I also authorize this office to remind me of my pre-medication on any postcard reminders that the office will mail to me.

{Signature of Patient or Parent/Legal Guardian}

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 acknowledgment
- Patient reviewed Privacy Practices but elected not to take a copy home
- Other (Please Specify)

Employee signature: _____ Date: _____



P R E C I S I O N D E N T A L
GENERAL & COSMETIC DENTISTRY

Financial Policy

We want to avoid any misunderstanding about our financial policy as it relates to your responsibilities for your account. Please read the following information and address our staff with any questions.

1. If you have dental insurance, our dental staff will be glad to help you obtain the appropriate dental benefits from your insurance carrier and bill your carrier as a courtesy. However, you are ultimately responsible for the fees associated with your dental care. Please keep in mind that the contractual arrangement is between you and your insurance company; Precision Dental is a 3rd party provider responsible only for the delivery of your dental services.
2. We accept cash, personal check, money order, cashier's check and credit cards (Visa, Discover, MasterCard, and American Express), as well as Care Credit credit services.
3. Portions of your bill may not be paid by the insurance carrier and must be paid by you. Any insurance deductible or co-payment required by your insurance carrier **is due at the time services are rendered.**
4. If you do not have insurance coverage or if you have a discount policy, payment is due at the time services are rendered unless other financial arrangements have been made prior to your appointment.
5. If your treatment plan requires a high out-of-pocket expense, our office manger can assist you in arranging financing or a payment schedule, upon approval.
6. If you fail to keep your scheduled appointment or cancel your appointment without 24 hours notice, your account will be charge a \$35 broken appointment charge for each hour of time that was reserved for your services.

Additional Terms

1. Balances unpaid after 30 days from the date of billing are subject to a finance charge at a rate of 3% per month (37% per annum).
2. Accounts referred to a collection agency will have collection costs added in the amount of 30% of the outstanding balance, together with court costs and reasonable attorney's fees.

Thank you for taking the time to familiarize yourself with our financial policy.

I acknowledge that I have read the above information and have been provided with an opportunity to ask questions about its content. I accept full financial obligation for the services that I agree to receive by the dental professionals at Precision Dental.

Patient Name: _____

Date: _____

Patient or Guardian Signature: _____