

Patient Registration Information

Welcome to our practice!

Thank you for selecting our dental healthcare team. Please fill out this form completely in ink. If you have any questions or concerns, please do not hesitate to ask for assistance - we will be happy to help!

Name _____

First

Mi

Last

Home address _____ City _____ State _____ Zip _____

Birthdate _____ Age _____ Social Security # _____

Home Phone _____ Work Phone _____

E-Mail Address _____

Referred by: Friend/family (Name) _____ Yellow pages Advertisement
 Dr. _____ Walk-in

Responsible Party

Name of responsible party _____

First

Last

Relationship

Address (if different from above) _____ Home Phone _____

City, State, Zip _____ Birthdate _____

Driver's license # _____ Social Security # _____

Employer _____ Work Phone _____

Insurance Information

Name of insured _____

First

Last

Relationship

Birthdate _____ Social Security # _____

Employer _____ Work Phone _____

Insurance Company _____ Group # _____ Phone _____

Ins. co. address _____ City _____ State _____ Zip _____

If you have dual insurance: Subscriber name _____

Birthdate _____ Social Security # _____

Employer _____ Work Phone _____

Insurance Company _____ Group # _____

Ins. co. address _____ City _____ State _____ Zip _____

Financial Arrangements

We will gladly bill your insurance for you and estimate your share at the time of treatment. **Payment for your portion is due at time of service.** For your convenience we offer the following methods of payment (please check the option you prefer):

_____ Cash or Check

_____ Mastercard or Visa

_____ Monthly payments (CARECREDIT approval required - please fill out attached application)

A billing charge of 1.5% monthly (annual rate 18%) is addressed on balances over 30 days.

I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I understand that chronically missed or cancelled appointments will result in a \$25 fee. I authorize Dr. Darke's office to bill my insurance company. I release any information needed and assign benefits to Robert A. Darke, DDS, PC.

Signature _____ Date _____

Patient Dental History

What is the primary reason for your visit? (e.g. checkup, pain, consultation) _____

When was you last dental visit? _____

Have your previous dental experiences been favorable? _____ If not, please explain _____

Name of previous dentist _____

Reason for change _____

Child's History (if applicable)

Is this your child's first visit? _____ Are any teeth hurting? _____

What is your child's favorite toy or activity? _____

Does your child have any mouth habits? (thumbsucking) _____

Is your child currently receiving fluoride? _____

May we use Nitrous Oxide Gas during treatment? _____

Please indicate with a check if you have had, or have any of the following?

- | | | | |
|--|---------------------------------|-----------------------------------|---|
| <input type="checkbox"/> Teeth sensitive to | <input type="checkbox"/> cold | <input type="checkbox"/> heat | <input type="checkbox"/> Gum recession |
| <input type="checkbox"/> Frequent toothache | <input type="checkbox"/> sweets | <input type="checkbox"/> pressure | <input type="checkbox"/> Periodontal (gum) treatment |
| <input type="checkbox"/> Habitual grinding or clenching of teeth | | | <input type="checkbox"/> Frequent filling replacement |
| <input type="checkbox"/> Jaw joint pain | | | <input type="checkbox"/> Discolored teeth |
| <input type="checkbox"/> Clicking or popping of jaw joints | | | <input type="checkbox"/> Crooked teeth |
| <input type="checkbox"/> Gum boils or abscesses | | | <input type="checkbox"/> Orthodontic treatment (braces) |
| <input type="checkbox"/> Does food catch between your teeth | | | <input type="checkbox"/> Injury to face or jaws |
| <input type="checkbox"/> Bleeding gums | | | <input type="checkbox"/> Root canal treatment |
| | | | <input type="checkbox"/> Wisdom tooth removal |

Patient Medical History

This information will help out in preventing serious medical complications or contagious disease. Any information given will be held in the strictest confidence and will be released only with your permission.

Name of Physician _____ Date of last physical _____

What medications have you taken in the last three months? _____

Are you under medical treatment? _____ If yes, describe _____

Do you smoke or use smokeless tobacco? _____ If yes, how much? _____

Have you ever had a reaction to any of the following: Penicillin Erythromycin Aspirin Codeine
 Other _____

Is your general health good?	Yes No	Bleeding problems	Yes No	Seizures	Yes No
Has there been a change in your health within the last year?	Yes No	TB Tuberculosis	Yes No	Herpes	Yes No
Have you been hospitalized or had a serious illness in the last 3 years?	Yes No	Artificial joint	Yes No	Asthma	Yes No
Have you had or been treated for:		Do you have or have you had:		Hepatitis	Yes No
Heart attack	Yes No	Diabetes	Yes No	Anemia	Yes No
Heart murmur	Yes No	Psychiatric care	Yes No	Stroke	Yes No
High blood pressure	Yes No	Radiation treatments	Yes No	Allergies	Yes No
Rheumatic fever	Yes No	Chemotherapy	Yes No	Cancer	Yes No
HIV positive/AIDS	Yes No	Prosthetic heart valve	Yes No	(Women)	
		Pacemaker	Yes No	Are you pregnant?	Yes No

Signature _____

Date _____

(To be completed by doctor) Medical record reviewed by:

Initials _____ Date _____

Initials _____ Date _____

Initials _____ Date _____

Initials _____ Date _____

Initials _____ Date _____

Initials _____ Date _____



Financial Policies

Hiddens Springs Family Dentistry accepts several forms of payment for dental treatment provided at this office.

Cash, debit card, personal check, business check (by authorized person)

Care Credit: We have an outside financing company that provides our patients with an interest free loan for dental treatment (actually, we pay the interest for you!) Everyone that qualifies can receive 90 days “same as Cash” short term advance. For treatment plans \$300.00 an interest free period of 3 month is provided. For dental treatment \$700.00 an interest free period for 6 months is provided. For dental treatment over \$1000.00, interest is not due for twelve months. A short application is required and we usually have an answer back within 10 minutes. After the interest free period, Care Credit does calculate the loan with a standard credit card interest rate, so it is your best interest to pay it off within the interest free time period.

Dental Insurance: Understanding your insurance coverage can be quite a challenge. Our goal is to assist you in maximizing your benefits. We care for patients from many different employers. Each company pays an insurance premium for specific coverage which fits the employer’s budget. Each plan is different in it’s covered services. We encourage you to become familiar with your policy exclusions, deductibles, and required co payments.

Our courtesy service to you includes:

- 1) Filing your insurance electronically within 24 hours of service and requesting payment be sent directly to us.
- 2) Following American Dental Association guidelines for coding procedures and filing insurance.

Our expectations of you as the owner of the policy:

- 1) Payment of fees not covered by your insurance plan at the time of service.
- 2) Please understand that the insurance payment belongs to you and we have no leverage to obtain payment from your insurance carrier.
- 3) Realize that dental insurance policies restrict payment for some services. They use restricted fee schedules (called UCR) and exclude some procedures based on prior conditions or length of time on the plan. All restrictions are based on the premium paid for the insurance, *not* our fees or recommended treatment.
- 4) You will have to take responsibility for any fees your insurance has not covered after 45 days. The balance on your account will be charged to your credit card.

I hereby authorize Dr. Robert A. Darke of Hiddens Springs Family Dentistry to release to my insurance company, information acquired in the course of my dental care. I hereby authorize benefits to be paid directly to Dr. Darke, I understand I am responsible for any unpaid balances.

I authorize Dr. Darke to charge my credit card with any unpaid balances 45 day after treatment has been rendered. I understand that treatment can not be completed until it is paid for (i.e. crowns will not be cemented, dentures will not be placed)

I understand that if I do not have a credit card on file, it will be necessary for me to have an open Care Credit account (90 days interest free) on which Hiddens Springs Family Dentistry can charge any balances not paid with 30 days.

_____ Date _____

Responsible Party Signature

What family members are covered by this agreement? _____

Credit Card on file *required*

_____ - _____ - _____
Please Circle M/C VISA

_____ - _____
Exp Date (MM/YY)