



# dental registration and history



## 1. patient information

Date \_\_\_\_\_

SS/HIC/Patient ID # \_\_\_\_\_

Patient Name \_\_\_\_\_  
Last Name \_\_\_\_\_  
First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Address \_\_\_\_\_

E-mail \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_

Birthdate \_\_\_\_\_

Married  Widowed  Single  Minor  
 Separated  Divorced  Partnered for \_\_\_\_\_ years

Patient Employer/School \_\_\_\_\_

Occupation \_\_\_\_\_

Employer/School Address \_\_\_\_\_

Employer/School Phone (\_\_\_\_) \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Birthdate \_\_\_\_\_

SS# \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## 2. dental insurance

Who is responsible for this account? \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

Is patient covered by additional insurance?  Yes  No

Subscriber's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

### ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_ and assign directly to \_\_\_\_\_ Name of Insurance Company(ies)

Dr. \_\_\_\_\_ 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.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Please print name of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

## 3. phone numbers

Home (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ Ext \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

Spouse's Work (\_\_\_\_) \_\_\_\_\_ Best time and place to reach you \_\_\_\_\_

**IN CASE OF EMERGENCY, CONTACT** (Specify someone who does not live in your household.)

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

## 4. dental history

Reason for today's visit \_\_\_\_\_

Former Dentist \_\_\_\_\_

City/State \_\_\_\_\_

Date of last dental visit \_\_\_\_\_

Date of last dental X-rays \_\_\_\_\_

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	Burning sensation on tongue	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth breathing	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding gums	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chew on one side of mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth pain, brushing	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blisters on lips or mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cigarette, pipe, or cigar smoking	<input type="checkbox"/> Yes <input type="checkbox"/> No	Orthodontic treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Clicking or popping jaw	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain around ear	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Dry mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Periodontal treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Fingernail biting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to cold	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Food collection between the teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to heat	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Foreign objects	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to sweets	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Grinding teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity when biting	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Gums swollen or tender	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sores or growths in your mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Jaw pain or tiredness	<input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you floss? _____	
		Lip or cheek biting	<input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you brush? _____	
		Loose teeth or broken fillings	<input type="checkbox"/> Yes <input type="checkbox"/> No		

# 5.

## HEALTH HISTORY

Physician's Name \_\_\_\_\_ Date of last visit \_\_\_\_\_

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine).  Yes  No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

- |  |  |                       |  |                                 |  |
|--|--|-----------------------|--|---------------------------------|--|
| AIDS/HIV   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Respiratory Disease             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting or dizziness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever                 | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis, Rheumatism                            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valves                          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Headaches             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shortness of Breath             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Joints                                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Trouble                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Problems        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Skin Rash                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Back Problems                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis Type _____  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Special Diet                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding abnormally, with extractions or surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke                          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Disease                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Feet or Ankles          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaundice              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Neck Glands             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemical Dependency                              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaw Pain              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemotherapy                                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillitis                     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Circulatory Problems                             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congenital Heart Lesions                         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumor or growth on head or neck | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cortisone Treatments                             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral Valve Prolapse | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcer                           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cough, persistent or bloody                      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Nervous Problems      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Weight Loss, unexplained        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Emphysema  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care      | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                 |  |
|  |  | Radiation Treatment   | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                 |  |

Do you wear contact lenses?  Yes  No

### Women:

Are you pregnant?  Yes  No

Due date \_\_\_\_\_

Are you nursing?  Yes  No

Taking birth control pills?  Yes  No

### Medications

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

\_\_\_\_\_  
\_\_\_\_\_

Pharmacy Name \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_

### ALLERGIES

Aspirin

Local Anesthetic

Barbiturates (Sleeping pills)

Penicillin

Codeine

Sulfa

Iodine

Other \_\_\_\_\_

Latex

# 6.

## updates (to be filled in at future appointments)

Has there been any change in your health since your last dental appointment?  Yes  No

For what conditions? \_\_\_\_\_

Are you taking any new medications? \_\_\_\_\_ If so, what? \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_

Has there been any change in your health since your last dental appointment?  Yes  No

For what conditions? \_\_\_\_\_

Are you taking any new medications? \_\_\_\_\_ If so, what? \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_

**Advance Dental  
515 E. Main St.  
Denville, NJ 07834**

Advance Dental LLC will always do our best to maximize the benefits you receive from your insurance plan. Please bring your insurance card and update us on all and any changes with your insurance so that we can efficiently obtain the proper information from your carrier.

Please be aware that:

1. All insurance policies are a contract between the patient and their insurance company. If there are any problems encountered in collecting benefits, the patient is ultimately responsible to promptly clear all balances in full with our office. Our office does not bill for treatment.
2. **Your insurance company must be in force on the actual date that the services are rendered. It does not matter if the treatment was started or pre-authorized previously.**
3. Assignment of benefits: Advance Dental, at our discretion, will accept assignments (direct payment) of benefits from your carrier. We will require that the patients make regular payments at each visit to cover any deductible and co-insurance (portion the insurance does not pay) so that there will be no balance due at the completion of your care.
4. Patients with 2 insurance plans: Recently there have been many changes in the coordination of benefits with two policies. In a growing percentage of cases this can still leave the patient with a required co-payment depending on how the second plan coordinates with the primary. We may not always know this until both insurance companies make their payment.
5. Full time college students: The insurance companies now require a letter or transcript from your school if you are using a plan provided by your parents.
6. Children: It is the responsibility of parents/guardian who brings the child to our office at the initial visit to have all the necessary insurance information. **The parent/guardian who brings the child at the first visit will ultimately have the responsibility of any and all unpaid balances on the account.**
7. Fee Structure: Many plans that we participate with require that we charge the fees that the plan stipulates. We will let you know if this is the type of plan you have.
8. Policy Termination: Please notify us immediately if your insurance changes, is terminated or you know that your plan will be terminated or changed at a future date.
9. Please keep all the correspondence and stubs you receive from your carrier. In addition, should you receive any statements from us please review them carefully and contact us immediately if you feel there is a discrepancy.

**By signing below, I accept the above and understand that I am ultimately responsible for payment of all treatment provided by Advance Dental.**

Patient Name: \_\_\_\_\_ Patient Signature: \_\_\_\_\_

Guardian/Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Advanced Dental, LLC  
515 East Main Street Denville, NJ 07834  
[www.denvilleadvancedental.com](http://www.denvilleadvancedental.com)

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### FINANCIAL AGREEMENT

- ❖ I acknowledge that payment is due at the time of treatment, unless other arrangements are made.
- ❖ I agree that parents, guardians, or personal representatives are responsible for all fees and services rendered for treatment of a minor/child.
- ❖ I accept full financial responsibility for all charges for services or items provided to me, to my minor/child, or to the patient for whom I have legal responsibility.
- ❖ I understand that filing a claim with insurance company does not relieve me from my responsibility for the payment of all charges.
- ❖ I acknowledge that all returned checks, for any reason, are subject to a charge of the check amount plus an additional \$35.00 return check fee.
- ❖ I understand all bills, regardless if I have insurance or not, must be paid within 90 days. If the balances run past 90 days on my account, I will be charged interest of 2.5% monthly until the balance is paid.
- ❖ I am aware that if any outstanding balance forces Advanced Dental LLC to pursue debt with an attorney or collections agency, additional charges/fees will be applied to my account.
- ❖ I acknowledge and agree to pay a broken appointment fee of \$50.00 if I do not show to my scheduled appointment or cancel the same day of my appointment. I also acknowledge that if this occurs more than 3 times, I may be subject to a side-booked appointment in the future until the habit has ceased.
- ❖ I understand that copies of records are always available within 5 business days and the fees are as follows:
  - ❖ a) search fee: \$10.00
  - ❖ b) copy fee per page \$1.00 ( not to exceed \$100.00)
  - ❖ c) x-ray copy fee \$20.00 per copy (digital print out)

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Signature of Patient, Parent, Guardian or Personal Representative

Date

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Please Print Name of Patient, Parent, Guardian or Personal Representatives

Date

Advanced Dental, LLC  
515 East Main Street Denville, NJ 07834  
www.denvilleadvancedental.com

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**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT**

I understand that, under the Health Insurance Portability & Accountability Act ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- ▶ Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- ▶ Obtain payment from third -party payers
- ▶ Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry our treatment, payment, or healthcare options. I also understand you are not required to agree to my restrictions, but if you do agree that you are bound to abide by such restrictions.

Patient Name: \_\_\_\_\_  
Signature: \_\_\_\_\_ Date \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_

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**For Office Use Only**

I attempted to obtain the patients signature in acknowledgement on the *Notice of Privacy Practice Acknowledgment*, but was unable to do so as documented below:

Date: \_\_\_\_\_ Initials: \_\_\_\_\_ Reason: \_\_\_\_\_