GALLERIA DENTAL

New Patient Registration

Patient Information

First Name: _____ Last Name: _____ Middle Initial: _____ Marital Status: _____

Preferred Name: _____ Date of Birth: _____ Gender: Male ☐ Female ☐

Social Security Number: _____ Driver's License #: _____

Address: _____ City, State: _____

Zip: _____ E-mail Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Emergency Contact Name: _____ Emergency Contact Phone: _____

Responsible Party *(if someone other than patient)*

Relationship to Patient: Patient's Parent ☐ Patient's Spouse ☐ Other: _____

First Name: _____ Last Name: _____ Middle Initial: _____ Marital Status: _____

Preferred Name: _____ Date of Birth: _____ Gender: Male ☐ Female ☐

Social Security Number: _____ Driver's License #: _____

Address: _____ City, State: _____

Zip: _____ E-mail Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Please tell us about yourself!

Occupation: _____ Employer: _____

How did you hear about us? _____ Whom may we thank for referring you? _____

Reason for today's visit? _____

How long has it been since your last dental cleaning? _____ Last dental x-rays? _____

Is there anything you would like us to know about you personally or about your past dental experiences?

_____

_____

On a scale of 1 to 10 (with 10 being the best), how happy are you with your smile? _____

What type of care are you seeking?

- ☐ Comprehensive Care; I want to do whatever it takes to keep my teeth and keep them healthy.
- ☐ Proactive Care; I want to keep my teeth, but only within a certain amount of time and money.
- ☐ Reactive Care; I only want to treat something if it is causing me discomfort.

Do you have **Dental Insurance**? Yes No

Please have **Driver's License** and **Dental Insurance card** available for copy.

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Medical History

Patient Name: _____ Date: _____

Health problems that you have or medication that you are taking could have an important interrelationship with your dental care. Thank you for answering the following questions.

Primary Care Physician: _____ Phone: _____ Last Visit: _____

Have you ever taken medications containing Bisphosphonates (bone strengtheners)? Yes No If yes, explain: _____

Need antibiotics before dental treatment? Yes No If yes, explain: _____

Current or past tobacco use? Yes No If yes, explain: _____

Are you **allergic** to any of the following? ☐ Latex ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Local anesthetics

☐ No Known Allergies ☐ Other:

WOMEN: Pregnant/trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

List all **medications** you are currently taking and reason you are taking them (you may attach list): ☐ No Medications

_____

_____

_____

Do you have (or have you ever had) any of the following? Please check all that apply. ☐ None

- ☐ AIDS/HIV Positive
- ☐ Anemia
- ☐ Angina (Chest Pain)
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Breathing Problems
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Cold Sores/Fever Blisters
- ☐ Cortisone Medicine
- ☐ Diabetes
- ☐ Drug/Alcohol Abuse
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Fainting/Dizziness
- ☐ Frequent Headaches
- ☐ Glaucoma
- ☐ Head Injuries
- ☐ Heart Attack/Failure
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis (A , B , or C)
- ☐ High Blood Pressure
- ☐ Hypoglycemia
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Mental Disorder
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Parathyroid Disease
- ☐ Radiation Treatments
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Stomach/Intestinal Disease
- ☐ Stroke
- ☐ Swelling of Limbs
- ☐ Thyroid Disease
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors or Growths
- ☐ Ulcers
- ☐ Yellow Jaundice
- ☐ Other:

Please explain any responses from above (date of diagnosis, treatment, etc.): _____

_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information could be dangerous to my health. It is my responsibility to inform Galleria Dental of any changes in medical status.

_____ _____

Signature (Patient or Responsible Party) If Responsible Party: Print Name and Relationship to Patient

GALLERIA DENTAL

Financial Policy

Thank you for choosing Galleria Dental as your dental provider. This form is to keep you updated of our current financial policies. We require you to read and sign this document prior to any treatment.

Payment is due at the time of service. We accept cash, check, MasterCard, Visa, and Discover. If your financial responsibility is larger than you can pay at the time of service, we can make financial arrangements, but this must be done prior to treatment. Any unpaid balances will have a 2% finance charge per month until paid. Accounts in bad standing will be turned over to a collection agency.

Insurance: We are happy to file your primary dental insurance carrier as a courtesy for our patients. Please bring your insurance card with you to each appointment. Your estimated patient portion is due at the time of service. The estimated insurance portion will be filed with your insurance provider. You are responsible for any payments, deductibles, downgraded procedures, or services that are not paid by your insurance. It's the patient's responsibility to verify their insurance before each appointment.

Dental insurance is not designed to cover all treatment costs. We make recommendations to benefit your oral health, and our recommendations may or may not be included in your insurance plan. Please check with your insurance provider on what benefits are covered in your plan. Any charges not paid by insurance are your responsibility. We are happy to file insurance predeterminations at your request.

Financing: If extended credit is needed, please ask us before treatment for an application. If approved, we will set up a custom contract to fit your needs. Please keep us informed of any financial changes so we may best help your needs.

Missed Appointments: We require a 48-hour notice to change or cancel an appointment. If appropriate notice is not given, a $50 per appointment hour charge may be assessed to the patient's account.

These policies apply to everyone. If you have any questions about our financial policy please feel free to ask. We are here to help.

I understand and accept the above Galleria Dental Financial Policy. I understand that I am responsible for all collection charges including attorney fees, court costs and interest charges.

Patient/Guardian Signature _____

Print Name _____ Date_____

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NOTICE OF PRIVACY PRACTICES (HIPAA)

I have received a copy of Galleria Dental's Notice of Privacy Practices.

Access to Dental Records: I authorize the following people to have access to my dental records, treatment plan, and financial information.

_____

_____

Print Name: _____

Signature: _____ Date: _____

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)

_____

_____