TIME 8:58 AM DATE 8/23/2010

PATIENT REGISTRATION

ID: _____ Chart ID: _____

First Name: _____ Last Name: _____ Middle Initial: ____

Patient Is: ☐ Policy Holder Preferred Name: _____

☐ Responsible Party

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: ____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

○ Responsible Party is also a Policy Holder for Patient ○ Primary Insurance Policy Holder ○ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: _____ State / Zip: _____ _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ○ Male ○ Female Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic: _____

E-mail: _____ ☐ I would like to receive correspondences via e-mail.

Section 2 Section 3

Employment Status: ○ Full Time ○ Part Time ○ Retired

Student Status: ○ Full Time ○ Part Time

Medicaid ID: _____ Pref. Dentist:

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

Referred By: _____

Previous Dentist: _____

Emergency Contact: _____

Emergency Contact #: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

1. EXAMS, XRAYS, AND PROPHYLAXIS (CLEANINGS)

I hereby authorize the doctor and/or staff at this dental office to perform diagnostic and therapeutic procedures as may be necessary for proper dental care as agreed upon through consultation with me.

2. DRUGS, MEDICATIONS AND PRE-MEDICATIONS

I understand that antibiotics, analgesics, and local anesthetics can cause multiple adverse effects including but not limited to paresthesia, allergic reactions causing redness and swelling of tissues, pain, increased heart rate, itching, vomiting, and/or anaphylactic shock.

3. CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. For example, root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary.

4. REMOVAL OF TEETH

Alternatives to removal have been explained to me. (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize the dentist to remove the teeth and any other necessary procedures. Side effects to medications as described in section one under drugs may occur. I understand removing teeth does not always remove all of the tooth or infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, bruising, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue, and surrounding tissue (paresthesia) that can last for an indefinite period of time, fractured jaw, sinus complications involving openings and or infections requiring other surgeries, bleeding, chronic pain and dysfunction of the jaw joint (TMJ), vision or hearing loss, referred neck pain, and damage to surrounding teeth. I understand I may need further treatment by a specialist if complications arise during or following treatment, the cost of which is my responsibility.

5. CROWNS, BRIDGES, CAPS AND VENEERS

I understand that is is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size and color) will be my responsibility before cementation. It is also my responsibility to return for for permanent cementation within 30 days from tooth preparation. Excessive delays may allow for tooth movement. This may necessitate a remake of a crown, bridge, or cap. I understand there will be additional charges for remakes due to my delaying permanent cementation. I understand that due to the delay further treatment such as root canals, perio defects, gum problems, and even loss of the tooth can result. I understand that due to the very nature of a crown that tissue cannot attach like a natural tooth surface and subsequent periodontal defects and problems can occur.

6. ENDODONTIC TREATMENT (ROOT CANAL)

I realize there is not guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment even including tooth loss. I understand that I may need further treatment, by a specialist, if complications arise during or following treatments such as; twisted curved or blocked canals, preventing removal of all infected pulp from roots, broken instruments, filling past the end of the tooth, not completely filling the canal, all which may require more treatment and even possible surgery, the cost of which is my responsibility. Complications can occur such as; pain, swelling, bleeding, infections, numbness of the teeth, lips, tongue and surrounding tissue that can last for an indefinite period of time, muscle cramps and spasms, referred neck pain, chronic pain and dysfunction of the jaw joint (TMJ), reactions to medications as listed above in section one, bruises sinus complications, sight and hearing impairment, all possible requiring further treatment by a specialist, the cost of which is my responsibility. I understand the need to place a permanent restoration to the tooth; failure to do so may cause failure to the root canal and even tooth loss.

7. PERIODONTAL LOSS (TISSUE & BONE)

I understand that I have a serious condition, causing a gum and bone inflammation or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacement and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition. I understand failure to do advised treatment will cause progression of the disease and loss of my teeth.

8. FILLINGS

I understand that care must be exercised in chewing on fillings especially during the first 24 hours to avoid breakage. I understand that a more extensive filling than originally diagnosed may be required due to additional decay. I understand that significant sensitivity is a common after effect of a newly placed filling and this could lead to more work such as a root canal, crown, etc.

9. DENTURES AND PARTIALS

I understand that wearing of dentures is difficult. Sore spots, altered speech, and difficulty in eating are common problems. Immediate dentures (placement of dentures immediately after extraction) may be painful. Immediate dentures may require considerable adjusting and several reline. A permanent reline will be needed later. This is not included in the denture fee. I understand that it is my responsibility to return for delivery of the dentures. I understand that failure to keep my delivery appointment may result in poorly fitted dentures. If a remake is due to my delays of more than 30 days there will be additional charges.

10. TOOTH WHITENING

I understand tooth whitening is an elective procedure with results which can diminish with time and may vary with different individuals. Existing dental restorations may not whiten at all and some individuals experience sensitivity to temperature changes.

I acknowledge that I have received a copy of the DENTAL MATERIALS FACT SHEET.

I understand that dentistry is not an exact science and that therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance had been made by anyone regarding the dental treatment which I have requested and authorized. I understand that no other dentist or the professional corporations is responsible for my dental treatment.

I hereby authorize any of the doctors, hygienist, or dental auxiliaries of the dental association to proceed with and perform the dental restoration and treatments. I understand that this is only an estimate and subject to modification depending on unforeseen or previously undiagnosed circumstances that may arise during the course of treatment. I understand that regardless of any dental insurance coverage I may have, I am responsible for payment of dental fees. I agree to pay an attorney's fees, collection fees, or court costs that may be incurred to satisfy this obligation.

Should any dispute arise over dental services provided to me, that is , whether any dental service rendered as allegedly unnecessary, unauthorized or was improperly, negligently, or incompletely performed, said dispute will be submitted to an independent arbitrator. The decision of the arbitrator shall be binding on both parties. I have read, understood, and agreed to the above. I agree that a photocopy of this authorization shall be as valid and effective as the original forever. I am or legal age and legally competent to make this assignment.

Signature_____ **Date** _____

(Parent or Legal Guardian