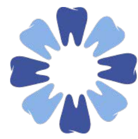
PATIENT REGISTRATION FORM



DENTAL CARE *of* South Brunswick

TODAY'S DATE:	

PATIENT INFORMATION

GENDER:	FEMALE		MALE		FAMILY STATUS:	SINGLE		MARRIED		DIVORCED		CHILD		OTHER	

FIRST NAME:	MI.	LAST NAME:	D.O.B	SOCIAL SECURITY #

STREET ADDRESS:	CITY:	STATE:	ZIP:

HOME PHONE:	CELL PHONE:	WORK:	EMAIL ADDRESS:

PATIENT EMPLOYER/SCHOOL:		OCCUPATION/MAJOR:	
WHOM MAY WE THANK FOR REFERRING YOU?			
IN CASE OF EMERGENCY WHO SHOULD BE NOTIFIED?	NAME:		PHONE:
PERSON RESPONSIBLE FOR THE ACCOUNT:		RELATION TO PATIENT:	

PLEASE ANSWER THE FOLLOWING QUESTIONS BY CHECKING THE APPROPRIATE BOX

1.	Do you have active dental insurance?	YES	NO
2.	Is the patient a full-time college student?	YES	NO
3.	Are you interested in automatic co-pay processing or automatic payment scheduling via credit card processing?	YES	NO

PRIMARY INSURANCE

POLICYHOLDER FIRST NAME:	MI.	LAST NAME:	D.O.B	SOCIAL SECURITY #

STREET ADDRESS: **if different than above*	CITY:	STATE:	ZIP:

DENTAL INSURANCE COMPANY:		SUBSCRIBERS EMPLOYER:	
INSURANCE CO. ADDRESS:		INSURANCE CO. PHONE #:	
GROUP OR POLICY #:		SUBSCRIBER ID#	

SECONDARY INSURANCE

POLICYHOLDER FIRST NAME:	MI.	LAST NAME:	D.O.B	SOCIAL SECURITY #

STREET ADDRESS: **if different than above*	CITY:	STATE:	ZIP:

DENTAL INSURANCE COMPANY:		SUBSCRIBERS EMPLOYER:	
INSURANCE CO. ADDRESS:		INSURANCE CO. PHONE #:	
GROUP OR POLICY #:		SUBSCRIBER ID#	

INSURANCE AUTHORIZATION & SIGNATURE ON FILE CERTIFICATION:

I hereby authorize Long Hill Dental and its associated providers to affix my name to all insurance claims submissions, documents and information requested by my dental insurance carrier relating to all dental benefits due to me and or my dependents. I also authorize payment of all dental claims for services rendered to be made payable directly to Long Hill Dental and its associated providers. I agree to be held responsible for all charges and dental services not paid, covered or denied by my insurance carrier. As a courtesy, LHD will electronically submit my insurance claim to my insurance carrier for payment on my behalf. LHD will be certain to provide my insurance company with all the necessary documentation to expedite the processing of my claims. Should my insurance company request additional information from me, I will submit the requested information in a timely manner. By doing so, this allows LHD to continue to provide a courtesy that many practices are eliminating: *"waiting for payment from my insurance company."* However, I will and agree to satisfy all co-pays and deductibles at the time of mine and/or dependents scheduled appointment(s). I understand that this consent and authorization will be valid until all claims have been adjudicated and until all balances for all dependents and myself have been satisfied in full.

AUTHORIZING & RESPONSIBLE PERSON:		DATE:	

CONSENT FOR TREATMENT & INFORMATION RELEASE:

I hereby consent to treatment, testing, diagnostic procedures (such as x-rays needed that aid in treatment planning and complete examination), and evaluation procedures that include my periodontal health. I understand that at times it may be necessary for LHD to communicate with my previous dentist, medical physicians and or specialty in order to better serve my dental/medical needs and for pre-screening medical concerns. Therefore, I permit the release of my dental and medical information and history to LHD. This authorization will be valid for 3 years after my last visit with LHD as an active patient. **Broken appointments, <u>without 48 hrs. advanced notice</u>, will incur a fee of $75.00 or more based on appointment length.**

AUTHORIZING & RESPONSIBLE PERSON:		DATE:	

PATIENT REGISTRATION FORM

DENTAL HISTORY			
1.	Are you interested in orthodontic treatment (straightening of teeth)?	YES	NO
2.	Are you concerned about the whiteness of your teeth?	YES	NO
3.	Are you currently experiencing any discomfort or pain?	YES	NO
4.	Do your gums bleed while brushing or flossing?	YES	NO
5.	Do you grind or clench your teeth?	YES	NO
6.	Are you experiencing bad breath?	YES	NO
7.	Are you experiencing sensitivity to hot, cold and or sweets?	YES	NO
8.	Do you have or had sores in or around your mouth?	YES	NO
9.	Do you experience clicking or popping of the jaw?	YES	NO
10.	Do you have issues with food collecting between your teeth?	YES	NO
11.	How often do you brush your teeth?		
12.	How often do you floss your teeth?		
13.	In months, when was your last exam and cleaning		
	Last “full set” of x-rays (approx. 12-18 x-rays)		
NAME PREVIOUS DENTIST:		**PHONE NUMBER**	

MEDICAL HISTORY			
1.	Have you ever used a bisphosphonate medication such as: Fosamax, Actonel, Atelvia, Didronel, Boniva	YES	NO
2.	Have you ever taken any group of drugs collectively referred to as “fen-phen?” Such as Ionimin, Adipex, Fastin (phentermine), Pondimin (fenfluramine), and Redux (dexfenfluramine).	YES	NO
3.	Have you had any serious illness or operation? YES / NO *If yes, describe*		
4.	Have you ever had a blood transfusion? YES / NO **approx. date*		
5.	(**WOMEN**) Are you pregnant? YES / NO; Are you nursing? YES / NO; Taking birth control? YES / NO		
6.	Do you smoke or are you an ex-smoker? YES / NO; # OF YRS. SMOKING?; # OF YRS SINCE QUITTING		

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING? ***(check appropriate box)***

Aspirin		**Codeine**		**Iodine**		**Latex**		**Penicillin**		**Sulfa**		**Local Anesthetic**		**Barbiturates**		**Other**	

If you checked **other**, please specify the **allergy**:

Please list any medication/s that you are taking and the daily dosage:

NAME OF PHYSICIAN:		**PHONE NUMBER**	

MARK “YES” OR “NO” TO INDICATE IF YOU HAVE OR HAD ANY OF THE FOLLOWING:

AID/HIV	YES	NO	EPILEPSY	YES	NO	RESPIRATORY DISEASE	YES	NO
ANEMIA	YES	NO	FAINTING/DIZZINESS	YES	NO	RHEUMATIC FEVER	YES	NO
ARTHRITIS	YES	NO	GLAUCOMA	YES	NO	SCARLET FEVER	YES	NO
ARTIFICIAL HEART VALVE	YES	NO	HEADACHES	YES	NO	SHORTNESS OF BREATH	YES	NO
ARTIFICIAL JOINT	YES	NO	HEART PROBLEMS	YES	NO	SINUS TROUBLE	YES	NO
ASTHMA	YES	NO	HEPATITIS **TYPE?**	YES	NO	SKIN RASH	YES	NO
BACK PROBLEMS	YES	NO	HIGH BLOOD PRESSURE	YES	NO	SPECIAL DIET	YES	NO
BLEEDING ABNORMALLY, EXTRACTION/SURGERY	YES	NO	HERPES	YES	NO	STROKE	YES	NO
BLOOD DISORDER	YES	NO	JAUNDICE	YES	NO	SWOLLEN FEET OR ANKLES	YES	NO
CANCER	YES	NO	JAW PAIN	YES	NO	THYROID PROBLEMS	YES	NO
CHEMICAL DEPENDENCY	YES	NO	KIDNEY DISEASE	YES	NO	TONSILLITIS	YES	NO
CHEMOTHERAPY	YES	NO	LIVER DISEASE	YES	NO	TUBERCULOSIS	YES	NO
CIRCULATORY PROBLEMS	YES	NO	LOW BLOOD PRESSURE	YES	NO	TUMOR OR GROWTH	YES	NO
CONGENITAL HEART DISEASE	YES	NO	MITRAL VALVE PROLAPSE	YES	NO	ULCER	YES	NO
CORTISONE TREATMENT	YES	NO	NERVOUS PROBLEMS	YES	NO	VENEREAL DISEASE	YES	NO
COUGH, PERSISTENT OR BLOODY	YES	NO	PACEMAKER	YES	NO	WEIGHT LOSS, UNEXPLAINED	YES	NO
DIABETES	YES	NO	PSYCHIATRIC CARE	YES	NO			
EMPHYSEMA	YES	NO	RADIATION TREATMENT	YES	NO			

PLEASE PROVIDE ANY OTHER IMPORTANT MEDICAL INFORMATION HERE:

Thank You

&

WELCOME TO DENTAL CARE OF SOUTH BRUNSWICK