Patient Registration

Patient's Name _____ Date _____

Patient Information

Home Phone _____ Cell Phone _____

Work Phone _____ E-mail _____

Social Security # _____ Sex ☐M ☐F Age ____ Birthdate _____

☐Single ☐ Married ☐ Partnered for __ years ☐ Separated ☐ Divorced ☐ Widowed ☐ Minor

Address _____ City/State/Zip _____

Employer/School _____ Occupation _____

Employer/School Address _____ City/State/Zip _____

Whom may we thank for referring you? _____

Emergency Contact

In case of emergency, contact _____ Relationship _____

Home Phone _____ Cell Phone _____ Work Phone _____

Primary Insurance

Insurance Subscriber _____ Relation to Patient _____

Social Security # _____ Birthdate _____ Home Phone _____

Address _____ City/State/Zip _____

Person responsible employed by _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company _____

Member/Subscriber ID # _____ Group # _____ Contract # _____

Names of other dependents covered under this plan _____

Additional Insurance

Is patient covered by additional insurance? ☐Yes ☐No

Subscriber Name _____ Relation to Patient _____

ID#/Soc.Sec.# _____ Birthdate _____ Home Phone _____

Address _____ City/State/Zip _____

Subscriber employed by _____ Business Phone _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

Patient Registration

Patient's Name _____ Date _____

Authorization

I certify that I, and/or my dependent(s), have insurance coverage with Insurance Company Name:_____ and assign directly to Dr. Stoycheva and/or First Place Dentistry all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charge whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above name dentist/dental clinic may use my health care information and may disclose such information to the above names 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.

_____ _____
Signature of Patient, Parent, Guardian, or Personal Representative Date

_____ _____
Print Name Relationship to Patient

Acknowledgement of Receipt of Notice of Privacy Practices

You may refuse to sign this acknowledgement

I, the undersigned, have received a copy of First Place Dentistry' Notice of Privacy Practices.

Patient's 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
- ☐ Communication barriers prohibited obtaining acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other, please specify: _____

_____

_____

_____

Dental History

Reason for today's visit _____

Date of last dental care _____ Date of last dental X-rays _____

Former Dentist _____

Address _____ City/State/Zip _____

Check the box if you have problems with any of the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between teeth
- ☐ Grinding Teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

How often do you floss? _____ How often do you brush? _____

Medical History

Physician's Name _____ Date of last visit _____

Have you had any serious illnesses or operations? ☐Yes ☐No If yes, describe _____

Have you ever had a blood transfusion? ☐Yes ☐No If yes, give approximate dates _____

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

(Women) Are you pregnant? ☐Yes ☐No Nursing? ☐Yes ☐No Taking birth control pills? ☐Yes ☐No

Check the box if you have any of the following:

- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsilitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

MEDICATIONS you are currently taking: _____

ALLERGIES: _____

Check the box if you have had any of the following problems or diseases:

- ☐ Artificial (Prosthetic) Heart Valve
- ☐ Previous Infective Endocarditis
- ☐ Damaged Valves in Transpl. Heart
- ☐ Congenial Heart Disease (CHD):
  - ☐ Unrepaired, Cyanotic CHD
  - ☐ Repaired (completely) in the past 6 months
  - ☐ Repaired CHD with residual results

Except for the conditions listed above, antibiotic prophylazis is no longer recommended for any other form of CHD.

Patient Smile Evaluation

Patient's Name _____ Date _____

To aid in our diagnosis and treatment of your esthetic concerns, please take a moment to answer the following questions.

Do you dislike the color of your teeth?	☐ YES	☐ NO
Do you have spaces between your teeth that bother you?	☐ YES	☐ NO
Do you have chips or uneven edges on your teeth?	☐ YES	☐ NO
Do you feel like your teeth are too long or too short?	☐ YES	☐ NO
Do you have dark fillings that show when you smile?	☐ YES	☐ NO
Do your gums show too much when you smile?	☐ YES	☐ NO
Are your teeth crowded or crooked?	☐ YES	☐ NO
Do you have existing crowns or dental work you consider "ugly"?	☐ YES	☐ NO
Are you self-conscious of your teeth and/or smile?	☐ YES	☐ NO
Has anyone (family member, friend, etc.) ever suggested that you should have something done with your teeth or smile?	☐ YES	☐ NO
Do you avoid smiling when you have your picture taken?	☐ YES	☐ NO
Would you like to improve your existing smile?	☐ YES	☐ NO
Do you wish you had a new smile?	☐ YES	☐ NO

What concerns do you have regarding dental treatment to improve your smile? (Check all that apply.)

- ☐ Fear of treatment
- ☐ Time of treatment concerns
- ☐ Financial concerns
- ☐ Distance to office
- ☐ Not understanding treatment
- ☐ Embarrassment
- ☐ Other (please specify)_____

_____

_____

Financial Policy

Patient's Name _____ Date _____

Thank you for choosing First Place Dentistry for your dental needs. The following is a statement of our financial policy. Please read and sign prior to treatment.

Initial Visit

All guests are expected to pay in full for all services at the time of service.

Financial Options

Fees are due and payable upon treatment with cash, check, bank card or insurance.

If extended payments are needed, we offer a finance plan with up to 12 months of interest free loans on approved credit.

To uninsured guests, for treatment plans greater than $500.00, a 5% courtesy will be given for payment made in full with cash or check prior to treatment.

Insurance Assignment

Most insurance plans will permit the direct assignment of your benefits to our office. We accept insurance assignment and your out-of-pocket expense at the time of treatment will only be what the insurance does not cover. However, insurance rarely covers 100% of dental treatment.
You are responsible for any fees that insurance does not cover.

Express Check-Out

For additional convenience, with your written permission, we can keep your ***Credit Card account number on-file***, for an express service every time you need to make a payment.

Patient Signature _____