

PATIENT REGISTRATION

garvin dentistry
FAMILY | COSMETIC

Patient Number _____

PATIENT INFORMATION

Patient's name: _____

Birthdate: ____/____/____

Street address: _____

Phone: (____) _____

City: _____ State: _____

Zip: _____

Social Security number: ____ - ____ - ____

If a child, parent's name: _____

Patient Status: Single Widowed Married Divorced Separated

Patient employed by: _____

Business address: _____

Phone: (____) _____

City: _____ State: _____

Zip: _____

Present position: _____

How long held: _____

In case of emergency, notify: _____

Phone: (____) _____

Person responsible for this account: _____

SPOUSE INFORMATION

Name of spouse: _____

Birthdate: ____/____/____

Social Security number: ____ - ____ - ____

Spouse employed by: _____

Business address: _____

Phone: (____) _____

City: _____ State: _____

Zip: _____

Present position: _____

How long held: _____

INSURANCE INFORMATION

Insurance Number _____

If you have insurance, name of insured: _____ Group No: _____

Name of insurance company: _____ Address: _____

Insurance phone #: _____

Is policy connected with a Union? Yes No If yes, name of Union: _____ Local No: _____

If spouse has insurance, name of insured: _____ Group No: _____

Name of insurance company: _____ Address: _____

Insurance phone #: _____

Is policy connected with a union? Yes No If yes, name of Union: _____ Local No: _____

CONSENT: The undersigned hereby authorizes Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patients needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance charge will be added to any overdue balance. I also assign all insurance benefits to the Doctor.

I am responsible for all costs incurred by the Dental Office for collecting past-due balances on accounts including, but not limited to, service fees, court costs, attorney fees, and agree to pay maximum statutory interest from the date of notice that the account or accounts have been declared delinquent.

Patient Signature (Parent of Child): _____ Date: _____

Whom may we thank for referring you: _____

Comments: _____

PATIENT NAME: _____ DATE: _____

DENTAL HISTORY

Name of previous dentist (optional): _____

Primary reason for this dental appointment: Exam Emergency Consultation

Last set of full x-rays: ____ / ____ / ____ Last teeth cleaning: ____ / ____ / ____

Do you have a specific dental problem? No Yes

Describe: _____

Do you have dental examinations on a regular basis? No Yes

Date of last visit: ____ / ____ / ____

Reason: _____

Are you happy with the appearance of your teeth? No Yes

Do you feel that your teeth look crooked? No Yes

Do you feel that your teeth look dark or discolored? No Yes

Do you feel that you have bad breath frequently? No Yes

Do you have frequent "bad taste" in your mouth? No Yes

Are you aware of any decayed teeth in your mouth? No Yes

Do you have a toothache at this time? No Yes

Is any other part of your mouth hurting? No Yes

Do you have any pain in your jaws, mouth or face? No Yes

Do your jaws click or crack? No Yes

Do your jaws ever lock? No Yes

Do you have difficulty opening your mouth wide? No Yes

Do you have problems with your gums? No Yes

Do your gums bleed when you brush your teeth? No Yes

Are your gums sore when you brush your teeth? No Yes

Do you have full or partial dentures? No Yes

If yes, which: Full Partial

Do you have any bridgework? No Yes

Do you have any missing teeth
(not including wisdom teeth)? No Yes

Is keeping all your teeth important to you? No Yes

Have you ever had difficulty with dental treatment? No Yes
Explain: _____

Have you ever had Novocaine anesthetic
(used to numb your teeth)? No Yes

Have you ever had allergic response to
Novocaine anesthetic? No Yes

Have you had any difficult extraction in the past? No Yes

Have you ever had any prolonged bleeding after
extractions in the past? No Yes

How often do you brush? _____

Floss? _____

Do you feel nervous about having dental treatment? No Yes

Have you ever had a bad experience in a dental office? No Yes
If yes, describe: _____

Do you ever grind or clench your teeth? No Yes

Have you ever had orthodontic treatment
(tooth straightening)? No Yes

Do you smoke? No Yes
How long? _____

How much? _____

Do you chew tobacco? No Yes

Garvin Dentistry Financial Policy

Thank you for choosing our office as your dental health care provider. We are committed to providing you with high quality dental care so that you may attain optimum oral health. Everyone benefits when office and financial policy arrangements are understood.

Payment is due at the time service is provided unless prior written/signed financial arrangements have been made. If crowns, bridges, dentures, or partial dentures are to be fabricated by a dental laboratory, a 50% deposit will be required at the time of the first impression appointment. The remaining balance is due at the time the prosthesis is cemented or inserted.

We accept cash, personal checks, Visa, MasterCard, Discover, American Express and Care Credit. *We are happy to offer 5% discount to patients who pay in full with cash or check at time of service.* Returned checks will be subject to additional fees. Accounts with balances at 90 days are subject to finance charges and the collection process.

If you have dental insurance, as a courtesy to you, we will file your claim with your insurance company, but we ask that you pay your deductible and co-payment, *which is the estimated amount not covered by your insurance policy,* at the time we provide service. We must emphasize that this is only an estimate and all charges you incur are your responsibility regardless of your insurance coverage. Insurance companies have a wide variety of rules, plan limitations and exclusions that our office may not be aware of. Dental insurance is a benefit for the patient provided by their employer and the contract lies between the patient, employer and the insurance company. Our office is not a party to that contract. We will cooperate fully with the regulations and requests of your insurance company to assist in your claim being paid. However, this office will not enter into a dispute with your insurance company over any claim. Insurance payments are generally received within 30 days from the time of filing. Once insurance has paid their share, a statement will be sent to you for any remaining balance and will be due upon receipt. If your insurance company has not made payment within 60 days, we will ask you to contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time. **Any account balances that remain over 90 days are subject to finance charges and the collection process.**

All patients must provide an ID card and Insurance card (if applicable) to be copied at the time of the appointment. *Your complete insurance information must be presented at the time services are provided.* Insurance claims cannot be back dated as this is considered fraud. Most benefits will be verified before your insurance company can be billed.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our policies. *Significant costs are incurred in carrying our patients' accounts. To control these costs and help keep fees down, it is necessary to adhere to these policies.* We also realize that temporary financial situations may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

CONSENT: I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS MY DENTAL CLAIM. I AUTHORIZE PAYMENT OF DENTAL BENEFITS TO GARVIN DENTISTRY FOR SERVICES RENDERED. I UNDERSTAND THAT ANY BALANCE LEFT UNPAID BY MY INSURANCE CARRIER IS MY COMPLETE RESPONSIBILITY. I FURTHER ACKNOWLEDGE I WILL BE RESPONSIBLE FOR REASONABLE COLLECTION FEES, ATTORNEY FEES AND COURT COSTS INCURRED IN ANY ATTEMPT BY PROVIDER TO COLLECT AMOUNTS I MAY OWE.

Signature _____ **Date:** _____

Broken Appointment Policy

It has recently become important that our office begin to re-implement our broken appointment policy. The need may not apply to you individually, however we ask that you review and sign the policy below to ensure that you are aware of it.

For regular appointments of 60 minutes or less, we require at least 48 hours notice for any changes or cancellations.

For appointments 90 minutes or longer, we require at least 72 hours notice for any changes or cancellations.

There will be a \$75 charge for failed or cancelled appointments without sufficient notice.

In order to avoid a fee, it is recommended that cancellations be made by reaching our office during business hours.

(print)

Name

Signature

Date