# Eldorado Family Dentistry and Orthodontics

# Patient Registration

## Patient information

Thank you for choosing our practice for your dental needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

(Please Print)

Name _____ Date _____ SS # _____
First Middle Initial Last

Address _____ City _____ State _____ Zip _____

Sex: ☐ Female ☐ Male Birthdate _____ email _____

Home Phone (_____)_____ Cell Phone (_____)_____ Work (_____)_____

Do you prefer to receive calls at: ☐ Home ☐ work ☐ Cell ☐ No Preference

☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Separated ☐ Divorced ☐ Partner for _____years

Patient Employer/School _____ Occupation _____

Employer/School Address _____ City _____ State _____ zip _____

Spouse or parent's name _____ Employer_____ Work Phone (_____)_____

Person to contact in case of emergency _____Phone (_____)_____

How did you hear about us? ☐ Insurance ☐ Billboard ☐ Ad Pages ☐ Internet ☐ Phone Book ☐ Mailer
☐ Patient/Friend _____ ☐ Other _____

## Responsible party

Name of person responsible for this account _____ SS# _____

Relationship to patient _____ Phone (_____)_____

Address _____ City _____State _____ Zip _____

Name of employer _____ Work Phone (_____)_____

# Insurance information

Name of insured _____Relationship to patient _____

Birthdate _____ Social Security # _____ Date employed _____

Name of employer _____ Work Phone (_____)_____

Address _____ City _____ State _____ Zip _____

Insurance Co. _____ Group # _____ Employer # _____

DO YOU HAVE ADDITIONAL INSURANCE? ☐ No ☐ Yes IF YES, PLEASE COMPLETE THE FOLLOWING:

Name of insured _____ Relationship to patient _____

Birthdate _____ Social Security # _____ Date employed _____

Name of employer _____ Work Phone (_____)_____

Address _____ City _____ State _____ Zip_____

Insurance Co. _____ Group # _____ Employer # _____

# Dental history

Name _____ Age _____ Date of last exam _____

Former Dentist _____ Date of last dental x-rays _____

Reason for today's visit _____

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

Please check any of the following conditions that apply to you:

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

# Medical History

Physician _____ Date of last visit _____

Please list all medications you are currently taking _____

Allergies _____ If none, please check here ☐ (No allergies)

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

Check (√) if you have had any of the following. If not applicable, please check here ☐ (No medical problems)

| | | | |
|---|---|---|---|
| ☐ AIDS | ☐ Congenital Heart Lesions | ☐ Hepatitis | ☐ Rheumatic Fever |
| ☐ Anemia | ☐ Cortisone Treatments | ☐ Hernia Repair | ☐ Scarlet Fever |
| ☐ Arthritis, Rheumatism | ☐ Cough, Persistent | ☐ High Blood Pressure | ☐ Shortness of Breath |
| ☐ Artificial Heart Valves | ☐ Cough up Blood | ☐ HIV positive | ☐ Skin Rash |
| ☐ Artificial Joints | ☐ Diabetes | ☐ Jaw Pain | ☐ Stroke |
| ☐ Asthma | ☐ Epilepsy | ☐ Kidney Disease | ☐ Swelling of Feet or Ankles |
| ☐ Back Problems | ☐ Fainting | ☐ Liver Disease | ☐ Thyroid Problems |
| ☐ Bleeding Abnormally | ☐ Glaucoma | ☐ Mitral Valve Prolapse | ☐ Tobacco Habit |
| ☐ Blood Disease | ☐ Headaches | ☐ Nervous Problems | ☐ Tonsillitis |
| ☐ Cancer | ☐ Heart Murmur | ☐ Pacemaker | ☐ Tuberculosis |
| ☐ Chemical Dependency | ☐ Heart Problems | ☐ Psychiatric Care | ☐ Ulcer |
| ☐ Chemotherapy | Describe _____ | ☐ Radiation Treatment | ☐ Venereal Disease |

□ Circulatory Problems □ Hemophilia □ Respiratory Disease □ Pins, Plates, Screws

Have you ever taken any of these medications?

**Diet Medications:** □ Dexfenfluramine □ Fen-phen □ Pondimin □Redux

**Blood Thinners:** □ Coumadin □ Warfarin

**Other:** □ Levoxyl □ Synthroid

## *Certification and assignment*

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with _____

Name of Insurance Company(ies)

And assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed or for one year from the date signed below.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative Date

**Name of Practice: Eldorado Family Dentistry and Orthodontics**

# Acknowledgement of Receipt of Notice of Privacy Practices

The Health Portability and Accountability Act of 1996 requires that health care providers give patients a copy of the office Notice of Privacy Practices and make a good faith effort to obtain an acknowledge of receipt of same. You may refuse this acknowledgement form.

**By signing this form, I confirm that I have received a copy of the office Notice of Privacy Practices.**

**Print Name: _____**

**Signature: _____**

**Date: _____**

# Eldorado Family Dentistry and Orthodontics
# Office Consent Form

## 24 HOUR NOTICE FOR CANCELLATION

I agree to give **24 HOURS NOTICE** if I need to **CANCEL** or **RESCHEDULE** my appointment. If I do not, I will have to pay a broken appointment fee of **$25.00**.

## LATE APPOINTMENTS

If I am more than **15 MINUTES LATE** for my appointment, I will either take the time remaining for my appointment or reschedule and pay a broken appointment fee of **$25.00**

## LIMITATIONS OF INSURANCE COVERAGE

Insurance may not cover every procedure that we recommend. Some examples might include: **Nitrous Oxide, Temporary Dentures, Removal of Crowns or Bridges, Bleaching or Cosmetic Work**. I understand that what might be quoted as my portion (co-payment) is only an **ESTIMATE**.

## I AGREE TO BE FINANCIALLY RESPONSIBLE FOR WHAT INSURANCE DOES NOT COVER!

## FILING OF DENTAL INSURANCES FOR THE PATIENT

We routinely file insurance claims for the patient as a **courtesy**. The patient is still **fully responsible** for payment of all charges incurred within the office. We reserve the right to discontinue filing insurance claims for the patient at

any time. If this occurs, the patient will then be **responsible for payment of all fees in full** at the times service is rendered.

## FAMILY MEMBERS IN THE TREATMENT AREAS

We have limited amount of space in the treatment areas of our office. Our facilities do not allow for non patients to be present chair side. One adult may accompany a minor to the treatment areas if you desire. However, we do ask that no more than one family member be present. Also, please arrange for childcare when appropriate. We cannot be responsible for managing children that are with adults undergoing treatment. **Our services require the full attention of our staff and doctors.**

## REQUESTING RECORD TRANSFERS

Professional courtesies are between dentists. I agree not to request records until I have a new dentist. If I do request a copy of my records, I will pay the fee of **$25.00**.

## I AGREE WITH THIS INFORMATION PROVIDED. I HAVE READ THIS FORM AND CONSENT TO TREATMENT.

**I understand that I am signing this form as it is written. If any changes are to be made a new form will be provided to me.**

Sign: _____ Date: _____