Patient Registration Form

Patient Information

Patient's First Name	Middle Name	Last Name (as it appears on insurance card or ID)

Sex	Marital Status	Date of Birth (Age)	Social Security Number

Patient's Address	City	State	Zip

Home Phone	Mobile Phone	Email Address

Referred by		

Patient Employer/School Information

Employer/School	Occupation	Employer/School Phone

Employer/School Address	City	State	Zip

Emergency Contact Information

Emergency Contact Name	Emergency Contact Phone	Relation to Patient

Billing and Insurance

Primary Dental Insurance

Insurance Company	Plan

Plan Number	Group Number	Insured's Employer/School

Insured's Name (as it appears on insurance card or ID)	Relation to Patient	Insured's Phone Number

Insured's Address	City	State	Zip

Insured's Social Security Number	Insured's Birthdate	

Secondary Dental Insurance

Insurance Company	Plan

Plan Number	Group Number	Insured's Employer/School	Insured's Social Security Number

Insured's Name (as it appears on insurance card or ID)	Relation to Patient	Insured's Phone Number

Responsible Party

Billing Name (if other than patient)	Phone	Relation to Patient

Address	City	State	Zip

Reason for Visit

What brings you to the office today?

Allergies

Are you allergic to any of the following?

- ☐ Adhesive Tape
- ☐ Barbiturates (Sleeping Pills)
- ☐ Codeine
- ☐ Antibiotics
- ☐ Aspirin
- ☐ Sulfa
- ☐ Latex
- ☐ Iodine
- ☐ Local Anesthetics

Do you have any other allergies?

Name _____ Reaction _____

Name _____ Reaction _____

Current Medications

Are you currently taking any blood thinners?

☐ Yes ☐ No

What medications are you currently taking?

Name _____ Dosage _____ Frequency _____

Name _____ Dosage _____ Frequency _____

Name _____ Dosage _____ Frequency _____

Hospitalizations & Surgeries

Reason _____ Date _____

Reason _____ Date _____

Reason _____ Date _____

Dental History

When was your last dental exam?

Date _____

When were your last dental x-rays taken?

Date _____

How often do you brush? # times/day _____

How often do you floss? # times/day _____

Do you grind your teeth?

☐ Yes ☐ No

Have you ever had orthodontic (braces) treatment?

☐ Yes ☐ No

Have you ever had periodontal (gum) treatments?

☐ Yes ☐ No

Do you have any of the following?

- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ Blisters on Mouth
- ☐ Broken Fillings
- ☐ Clicking Jaw
- ☐ Dentures
- ☐ Difficulty Opening or Closing
- ☐ Dry Mouth
- ☐ Difficulty Chewing
- ☐ Ear Pain
- ☐ Jaw Pain
- ☐ Loose Teeth
- ☐ Mouth Pain
- ☐ Mouth Sores
- ☐ Partials
- ☐ Sensitivity to Cold
- ☐ Sensitivity to Heat
- ☐ Sensitivity to Sweets
- ☐ Sensitivity to Pressure
- ☐ Swollen Gums

Past Medical History

Have you ever had any of the following?

- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ AIDS / HIV
- ☐ Bleeding Disorder
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Bowel Disorder
- ☐ Cancer
- ☐ Diabetes
- ☐ Depression
- ☐ Eating Disorder
- ☐ Epilepsy
- ☐ Hay Fever
- ☐ Heart Disease
- ☐ Heart Problems
- ☐ Hepatitis - A, B, or C
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Joint Disorder
- ☐ Kidney Disorder
- ☐ Liver Disorder
- ☐ Lung Disease
- ☐ Lupus
- ☐ Measles
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Skin Disorder
- ☐ Stroke
- ☐ Stomach Ulcer
- ☐ Substance Abuse
- ☐ Thyroid Disorder
- ☐ Tuberculosis
- ☐ Venereal Disease

Lifestyle Factors

Have you ever smoked?

☐ Yes ☐ No # of years _____ # packs/day _____

Do you smoke now?

☐ Yes ☐ No # packs/day _____

Do you use recreational drugs?

☐ Yes ☐ No types? _____ # times/week _____

How much alcohol do you drink per week?

drinks/week _____

How much caffeine do you drink per day?

drinks/day _____

Women Only

Are you pregnant?

☐ Yes ☐ No

Are you breastfeeding?

☐ Yes ☐ No

What is your method of birth control?

Terms & Agreements

Payment Policy

In all cases, Crescent Dental patients agree to the following payment policies: Payment in full of the estimated patient portion of the fees is due no later than when services are rendered. For comprehensive treatment plans requiring multiple office visits, Crescent Dental requires a minimum deposit of 50% of the total estimated patient portion of the fees at the start of treatment.

Privacy Policy

By signing below, I acknowledge that I have read Crescent Dental's Notice of Privacy Practices, as mandated by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). If you are very curious and enjoy reading legalese, please ask our front desk for a paper copy.

Missed Appointments

At Crescent Dental we have a mission: Make top-quality dental care accessible to everyone. In order to provide amazing service without charging an arm and a leg, it is essential for us to keep our chairs fully booked. When a guest misses an appointment, our staff do two things: First they cry and ask "why doesn't anyone like me?" and then they sit in melancholy, staring at the floor. Neither of these activities help us achieve our world-changing vision. To this end, we are obliged to charge a $75 "Missed Appointment Fee" for all cancelled or rescheduled appointments without AT LEAST 24 HOURS NOTICE. Arriving more than 15 minutes late for appointment is considered a miss.

DENTAL INSURANCE

As a service to all of our patients with dental insurance, we will happily file your claims for you. However, if you DO NOT agree to any of the following terms, you hereby waive the privilege of having your claim filed for you. As such, you will then be responsible for the total cost of your treatment at the time of service unless otherwise agreed upon. If you choose to file your own claim and need assistance, let us know, we would love to help.

Insurance: Permission to File

To the extent permitted by law, I consent to Crescent Dental's use and disclosure of my Protected Health Information to carry out payment activities in connection with my insurance claim. This information will be used exclusively for the purpose of evaluating and administering claims for benefits. I further authorize and direct payment to Crescent Dental of the dental benefits otherwise payable to me.

Insurance: Pre-treatment Estimates

Insurance estimates are not a guarantee of coverage. We pride ourselves on being able to provide you with an accurate estimation of your cost, but nothing can match the accuracy of getting an estimate directly from your insurance prior to treatment. We strongly recommend pretreatment estimates on procedures with a cost of greater that $300 to help avoid any unwanted surprises. We will send any pre-treatment estimates on your behalf and typically take between 1-3 weeks to be returned to us from your insurance. If your ailment requires immediate treatment, or you do not want a pre-treatment estimate to be sent, we cannot guarantee insurance payment. It is your responsibility to pay any charges not paid by your insurance if a pre-treatment estimate is not sent.

Signature of Patient or Authorized Guardian: _____ Dare: _____