SHERIDAN DENTAL

Patient Registration

Welcome to our Practice

Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you. We look forward to working with you in maintaining your dental needs.

Name: (Last) _____ (First) _____ (MI) ___ I prefer to be called: _____

Date of Birth: _____ Social Security #: _____ Gender: ☐ Male ☐ Female

Marital Status: ☒ Single ☐ Married ☐ Divorced ☐ Widowed Student Status: ☒ Non-Student ☐ Part-Time ☐ Full-Time

Phone: Home _____ Work _____ Cell _____

Address: Street _____ City _____ State ___ Zip _____

E-Mail Address _____

What is your Preferred Contact Method? ☐ Home Phon ☐ Work Phone ☐ Cell Phon ☐ E-Mail

Emergency Contact Name: _____ Emergency Contact Number: _____

How did you hear about us? ☐ Google ☐ Facebook ☐ Current Patient _____

Preferred Pronoun: ☐ Other: _____

☐ She/Her/Hers ☐ He/Him/Hi ☐ They/Them/Theirs

Insurance Information

Primary Insurance Subscriber Name: _____

Subscriber Date of Birth: _____ Subscriber S.S. #: _____

Your Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child

Insurance Company: _____ Ins. Co. Phone: _____

Employer: _____ Group Name: _____ Group #: _____

Secondary Insurance Subscriber Name: _____

Subscriber Date of Birth: _____ Subscriber S.S. #: _____

Your Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child

Insurance Company: _____ Ins. Co. Phone: _____

Employer: _____ Group Name: _____ Group #: _____

Authorization

☐ I certify that I am covered by the Insurance Co. listed above and I assign all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any copayment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____

Patient/Guardian Signature

SHERIDAN DENTAL

Health History

Patient Name: _____ **Date of Birth:** _____
Last First

Dental History

Reason for Today's Visit: _____

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

Are you Apprehensive about dental treatment?	☐ Yes ☐ No
Have you ever had Periodontal (Gum) therapy?	☐ Yes ☐ No
Have you ever have orthodontic (braces) treatment?	☐ Yes ☐ No
If yes, are you still happy with your result?	☐ Yes ☐ No
Do your gums BLEED, feel TENDER, or IRRITATED?	☐ Yes ☐ No
Are your teeth SENSITIVE to hot, colds, sweets or pressure?	☐ Yes ☐ No
Are you aware of GRINDING or CLENCHING your teeth?	☐ Yes ☐ No
Do you have HEADACHES, EARACHES or NECK PAIN?	☐ Yes ☐ No

Are you unhappy with the appearance of your smile? Would you like it to look different?

If yes, please explain: _____

Are you in pain? If yes, please explain: _____

Are there any special considerations you would like for us to take? _____

Medical History

Physician's Name: _____ Date of last visit: _____

(Women) Are you pregnant? ☐ Yes ☐ No

Check (X) if you have or have had any of the following:

☐ Alzheimer's	☐ COPD Lung Disease	☐ Jaw Pain	☐ Rheumatic Fever
☐ Arthritis / Rheumatism	☐ Diabetes	☐ Kidney Disease	☐ Sinus Problems
☐ Artificial Heart Valves	☐ Headaches	☐ Kidney Failure	☐ Skin Diseases
☐ Artificial Joints	☐ Heart Murmur	☐ Liver Disease	☐ Skin Rash
☐ Asthma	☐ Heart Problems	☐ Osteoporosis	☐ Sleep Apnea
☐ Back Problems	☐ Hepatitis (Type ___)	☐ Pacemaker	☐ Stroke
☐ Bleeding Problems	☐ High Blood Pressure	☐ Psychiatric Treatment	☐ Thyroid Problems
☐ Cancer	☐ High Cholesterol	☐ Radiation Treatment	☐ Tobacco Habit
☐ Chemotherapy	☐ HIV+ / AIDS	☐ Respiratory Issues (EG-TB)	☐ Ulcer

☐ **NO KNOWN HEALTH PROBLEM**

Do you have any other serious medical conditions? If yes, please explain:

_____

Check (X) if you are Allergic to any of the following:

☐ Aspirin	☐ Ibuprofen, Naproxen or NSAIDS	☐ Latex	☐ Sulfa Drugs
☐ Codeine	☐ Jewelry / Metals	☐ Penicillin or Amoxicillin	☐ Tylenol
☐ Dental Anesthetics	☐ Other: _____		

Please list all medications you are currently taking:

1 _____	3 _____	5 _____	7 _____
2 _____	4 _____	6 _____	8 _____

Pharmacy: _____ Phone #: _____

Authorization

☐ I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need.

PAYMENT IS DUE AT THE TIME OF SERVICE

PATIENT ACKNOWLEDGEMENT FORM FOR RECEIPT OF NOTICE OF PRIVACY PRACTICES CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization.
In refusing we may not be allowed to process your insurance claims.

The undersigned acknowledges a copy of the current effective Notice of Privacy Practices for this healthcare facility has been made available at www.raymondsheridandds.com/privacy-policy. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR/ FACILITIES IN THE FUTURE.

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION.
(This includes spouses, parents, step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Sheridan Dental reserves the right to contact you to confirm appointments, convey treatment/billing information, convey information on your health, and special services (I.E. events, fundraising, etc.)

If you wish to opt out of any form of contact please note here: _____

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Patient Name: _____ **Date of Birth:** _____
Last First

Parent/Legal Guardian Name: _____ Relationship to Patient: _____
(if signing on behalf of the patient)

_____
Patient/Guardian Signature Date

SHERIDAN DENTAL

Financial Policies

We are committed to providing you with the best possible care. If you have dental insurance, we want to help you receive your maximum allowable benefit. In order to achieve these goals, we need your assistance and your understanding of our financial policies. Please read this form in its entirety and sign at the bottom.

We encourage our patients to be familiar with the cost of their dental treatment. A full estimate is available to you before you consent to treatment. If you would like an estimate please be sure to request one.

- Patients without insurance; please make payment for your care at each office visit. Unless other arrangements are in place the following methods of payment are accepted: Cash or Check, Visa, MasterCard, and Discover. We also offer financing plans through multiple third party financial companies.
- Your insurance is a contract between you, your employer, and the insurance company. We are not a third party to that contract. As a service to you, we will help you file your insurance claim for reimbursement, providing we have complete and current insurance information. It is your responsibility to give our office your dental insurance information. We still consider the patient or responsible party to be liable for the account.
- Not all services are a covered benefit in all contracts. The insurance coverage purchased by your employer selects certain services they will not cover. You are responsible for deductibles and non-covered services. Please pay estimated portion as services are rendered. We would appreciate the remaining balances, if any, to be paid within 14 days after receipt of our billing statement.
- If you have any questions concerning our financial policies or any uncertainty regarding insurance coverage, PLEASE do not hesitate to ask. We are here to help you.
- If you find it necessary to cancel or change an appointment, please allow at least 2 business days prior notice. A cancellation fee of $50.00 will be charged for all late cancellations and no-show appointments.

I have read and agree to the Financial Policy stated above that applies to me.

Patient Name: _____ **Date of Birth:** _____
Last First

Financially Responsible Party Nam _____ Relationship to Patient: _____
(if signing on behalf of the patient)

_____
Patient/Financially Responsible Party Signature Date

*Please Note: Responsible party may need to be contacted to verify information.