

Patient Registration

Today's Date:		Preferred Nickname:			
Legal Name: Last:		First:		Middle:	Social Security #:
Date of Birth:	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Preferred Gender Pronoun <input type="checkbox"/> Male/He <input type="checkbox"/> Female/She <input type="checkbox"/> Other/They/Them		
Address:		City:		State:	Zip:
Occupation:		Employer:			
Cell Phone:		Home Phone:		Email:	
How did you hear about us?					
Other family members seen here:					
Emergency Contact Name:		Relationship:	Cell Phone:		Other Phone:

Dental Insurance Information *(Please give your insurance card to the receptionist)*

Subscriber's Name:		Date of Birth:	SSN:	Phone:	
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No	Address (if different):		Dental Insurance Company:		Group #:

What is the reason for your dental visit today?

Routine Visit Pain Swelling Bleeding Smile Concerns Trauma Other _____

Why did you leave your last dentist? Referring Doctor _____ Other _____

Any history of dental anxiety? **Y / N** Low Moderate High If yes, please explain: _____

Date of your last dental exam and/or cleaning: _____ Date of your last dental x-rays: _____

What in life gives you enjoyment? Music Reading Animals Children Working Exercise
 Other _____

MEDICAL HISTORY

Joint Replacement:

Have you had an orthopedic total joint replacement? **Y / N** **DATE:** _____

Heart Valve:

Have you had an artificial heart valve placed or history of infective endocarditis? **Y / N** **DATE:** _____

Women: Are you pregnant? **Y / N** Week # _____ Are you breastfeeding? **Y / N**

Tobacco use: Past Current **Type:** Cigarettes Cigars Smokeless/Chewing Pipe
Vape Marijuana Other (please list): _____

Medications. Please list all medications and supplements. <input type="checkbox"/> Check here if no medications	Allergies. Are you allergic to or had any past reaction to: <input type="checkbox"/> Check here if no known allergies
	Penicillin
	Acrylic
	Latex (rubber)
	Sulfa drugs or other antibiotics
	Anesthetics
	Animals
	Codeine or other narcotics
	Aspirin
	Hay fever/Seasonal
	Barbituates, sedatives, sleeping pills
	Food
	Metals
	Other

HEALTH CONDITIONS			<input type="checkbox"/> CHECK HERE if you have none of the below conditions
Cardiovascular Disease	Autoimmune disease	Stroke	
Chest Pain/Angina	Systemic Lupus	Hypo/Hyper Thyroidism	
Arteriosclerosis	Rheumatoid Arthritis	Glaucoma	
Congestive Heart Failure	Osteoarthritis	Hepatitis, Jaundice, or Liver disease	
Damaged Heart Valves	Asthma	Epilepsy/Seizures	
Heart Attack	Bronchitis	Fainting Spells	
Heart Murmur	Emphysema	Neurological Disorder <i>Specify:</i> _____	
High / Low Blood Pressure	Sinus trouble		
Congenital Heart Defect	Tuberculosis	Sleep Disorder	
Arrhythmia/Irregular Heartbeat	Cancer, Chemotherapy, and/or Radiation Treatment	Mental Health Disorder <i>Specify:</i> _____	
Mitral Valve Prolapse	Chest Pain upon Exertion		
Pacemaker	Chronic Pain	Recurrent Infection	
Rheumatic Fever	Diabetes <i>Type I or Type II</i>	Kidney Problems	
Alcohol/Drug Use		Osteoporosis	
Abnormal Bleeding	Eating Disorder	Swollen glands in neck	
Anemia	Gastrointestinal Disease	Severe headaches/migraines	
Hemophilia	G.E. Reflux or Heartburn	STDs	
Excessive Urination	Ulcers	AIDS or HIV Infection	
High Cholesterol	Severe or rapid weight loss	Cold sores/Herpes	
Do you have any disease, condition, or problem not listed above? Please explain:			

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me safely and effectively. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form. I hereby grant permission to the doctor to take x-rays, study models, photographs and any other diagnostic aids deemed appropriate to make a thorough diagnosis of my dental care. I understand any photographs may be used for documentation and for educational purposes.

Signature of Patient/Legal Guardian:	Date:
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Office & Financial Policy

At our dental practice, the payment of your bill is part of your treatment, and we kindly request payment at the time services are provided. As your dedicated dental care provider, our relationship is with you, our patient, and not with your insurance company. As a courtesy to you, we will submit all insurance claims to your insurance provider and provide you with an **estimate** of the portion they will cover. However, please remember that you are responsible for all charges incurred, regardless of insurance coverage.

Once your insurance pays its portion, we will send you a statement for any remaining balance, which is due upon receipt. In case your insurance has not made payment within 60 days, the unpaid balance becomes your responsibility and may be subject to finance charges for the collection process. If you should require assistance with financial arrangements, we require these arrangements to be made prior to your treatment appointment.

Credit Card Policy. Credit card payments will be allowed up to \$1,000 with no additional fees. For any amount over \$1,000, an additional 3% credit card processing fee will be applied to your account. To avoid the processing fee, we do accept checks or cash.

Cancellation & Late Policy. Your appointment time is reserved for you. If you are running late for your appointment, please contact us to see if we can accommodate you or reschedule for a different day/ time. Minimum 48 hours advanced notice is required for cancellations, and notifications can be left on our answering machine after business hours. Missed appointments will incur a \$125.00 charge per hour reserved for your treatment, and appointments exceeding two hours require a \$250 reservation deposit. If you keep your scheduled appointment, this deposit may be credited towards your treatment.

Cancelled Checks and Past Due Balances. All returned checks are subject to \$35 fee, and balances over 60 days will accrue interest at 18% annum. In the event of an unpaid account with past due balances, we may report it to all three major credit bureaus and assign it to a Collections Agency.

I have read and accept the terms of the above Financial Policy and Agreement and understand that I am fully responsible for payment of fees incurred regardless of any insurance. I have authorized Dr. Chen and Dr. Nagatomo to bill my dental insurance company and accept assignment of my dental benefits.

Signature of Patient/Legal Guardian:	Date:
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Privacy Policy

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

A copy of the Notice of Privacy Practices is available for your review at any time you request.

I, (please print name) _____, have received a copy of this office's **Notice of Privacy Practices**.

Signature of Patient/Legal Guardian:	Date:
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