Social Circle Dental

NEW PATIENT REGISTRATION

About you

E-Mail Address:_____

Name: _____
Last First Middle

I prefer to be called_____

Birthday_____/_____/_____ Age_____ SSN____-___-____

Home Address: _____
apt #_____ PO BOX_____
City_____ State_____ Zip_____
Your marital status _____Sex ☐ Male ☐ Female
Home phone# (_____)_____-_____
Cell phone# (_____)_____-_____
Work phone# (_____)_____-_____ Ext_____
Driver's license number:_____
Employer_____
Employer address_____
City_____State_____Zip_____
How long there?_____
Occupation_____
Where & When are best times to reach you?_____
How did you hear about us?_____
Whom may we thank for referring you?_____
Other family members seen by us_____
_____
_____
_____
Previous dentist_____
Present dentist_____
Person responsible for account _____

Spouse information

His / Her Name: _____
Employer_____
Work phone# (____)____-_____ Ext_____
SSN____-___-____ Birthday___/___/____
Driver's license number:_____

Relative or friend not living with you

His / Her Name: _____
Relationship_____
Home phone# (____)____-_____
Cell phone# (____)____-_____
Work phone# (____)____-_____ Ext_____

Dental Insurance Information

Primary insurance

Dental coverage? ☐Yes ☐No
Insurance Co name_____
Insurance Co Address_____
City_____ State_____ Zip_____
Insurance Co Phone# (_____)_____-_____
Group# (Plan, Local or Policy #)_____
Insured's name_____
Relationship_____
Insured's Birthday_____/_____/_____ SSN____-___-____
Insured's employer _____
Employer Address_____
City_____State_____Zip_____

Secondary insurance

Dental coverage? ☐Yes ☐No
Insurance Co name_____
Insurance Co Address_____
City_____ State_____ Zip_____
Insurance Co Phone# (_____)_____-_____
Group# (Plan, Local or Policy #)_____
Insured's name_____
Relationship_____
Insured's Birthday_____/_____/_____ SSN____-___-____
Insured's employer _____
Employer Address_____
City_____State_____Zip_____

Medical History

Do you have a personal physician? ☐Yes ☐No
Physician's Name_____
Phone# (____)___-_____ Date of last visit___/____/____
Your current physical health is:_____
Are you currently under the care of a physician? ☐Yes ☐No
Please explain_____
_____
Do you smoke or use tobacco in any other form? ☐Yes ☐No
Do you have tattoos or piercings? ☐Yes ☐No
Have you had any metal rods, pins or implants? ☐Yes ☐No
When? ___/___/____
Do you wear a cardiac pacemaker or have you had heart surgery?
☐ Yes ☐No When? ___/___/____
Are you required to take any pre-med (antibiotics) before dental work?
☐Yes ☐No What?_____

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Are you taking any prescription / Over-the counter drugs? ☐**Yes** ☐**No**

Please list or provide a list of all medications:_____.

_____

Have you ever taken bisphosphonate? ☐**Yes** ☐**No**

If so, which one? Fosamax Boniva Actonel Reclast

Medical History (Continued)

Women: Are you using a prescribed method of birth control? ☐**Yes** ☐**No**

Are you pregnant? ☐**Yes** ☐**No** **Week #**_____

Are your nursing? ☐**Yes** ☐**No**

Have you ever had any of the following diseases or medical problems? Please check YES or NO

yes	no		yes	/no	
☐	☐	Abnormal Bleeding /Hemophilia	☐	☐	Allergies or Hives
☐	☐	Artificial bones/ joints/ valves	☐	☐	Kidney disease
☐	☐	Chemotherapy(Cancer, leukemia)	☐	☐	Liver disease
☐	☐	AIDs related complex	☐	☐	Low blood pressure
☐	☐	Alcohol / Drug Abuse	☐	☐	Lupus
☐	☐	Anemia	☐	☐	Angina pectoris
☐	☐	Arthritis	☐	☐	Cerebral palsy
☐	☐	Asthma	☐	☐	Joint replacement
☐	☐	Blood transfusion	☐	☐	Nervous disorder
☐	☐	Colitis	☐	☐	Tumors or growths
☐	☐	Congenital heart defect	☐	☐	Mitral valve prolapse
☐	☐	Diabetes	☐	☐	Pacemaker
☐	☐	Difficulty breathing	☐	☐	Psychiatric treatment
☐	☐	Emphysema	☐	☐	Radiation treatment
☐	☐	Epilepsy / Seizures	☐	☐	Glaucoma
☐	☐	Excessive bleeding	☐	☐	Hay fever
☐	☐	Respiratory disease	☐	☐	Sinus problems
☐	☐	Artificial prosthesis	☐	☐	Stroke
☐	☐	Congenital heart disease	☐	☐	Thyroid problems
☐	☐	X-Ray or cobalt treatment	☐	☐	Tuberculosis (TB)
☐	☐	Fainting spells / seizures	☐	☐	Ulcers
☐	☐	Frequent headaches	☐	☐	Venereal disease
☐	☐	Rheumatic / Scarlet fever	☐	☐	Tonsillitis
☐	☐	Sickle cell disease / Traits	☐	☐	Head injuries
☐	☐	Heart attack / Surgery	☐	☐	Heart failure
☐	☐	Heart murmur	☐	☐	Chicken pox
☐	☐	Hepatitis / jaundice	☐	☐	Fever blisters
☐	☐	Herpes	☐	☐	Blood disease
☐	☐	High blood pressure	☐	☐	Drug addiction
☐	☐	Autism	☐	☐	Disability _____
☐	☐	Hospitalized for any reason	What for?_____		

Please list any serious medical condition(s) that you have ever had/have.

_____

_____

Are you allergic to any Drugs / Materials? Which ones?

_____

_____

Dental History

Why have you come to the dentist today?_____

_____

_____

_____

Are you currently in pain? ☐**Yes** ☐**No**

Your current dental health is:_____

Have you ever had a serious/ difficult problem associated with any previous dental work? ☐**Yes** ☐**No**

Do you floss daily? ☐**Yes** ☐**No** **Brush daily?** ☐**Yes** ☐**No**

Type of bristles on your toothbrush?_____

Have you ever had gum treatment? ☐**Yes** ☐**No**

Do your gums ever bleed? ☐**Yes** ☐**No** **Ever itch?** ☐**Yes** ☐**No**

Have you ever had periodontal disease? ☐**Yes** ☐**No**

Do you now or have you ever experienced pain / discomfort in you jaw joint ☐**Yes** ☐**No**

(TMJ/ TMD) ☐**Yes** ☐**No**

Are your teeth sensitive to ☐**Hot** ☐**Cold**

☐**The information and health history and preceding answers are true and correct to the best of my knowledge. I authorize and give consent to preform dental services agreed between doctor and patient and/or guardian to be necessary or advisable, including the use of local anesthesia and other medications as indicated. I agree that regardless of insurance coverage, I am responsible for payment for services rendered. If I ever have any changes in my health or if my medication changes I will, without fail, inform the doctor at my next appointment.**

Signature_____ **Date** _____

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Office Financial Policy

As a professional courtesy to our patients, we will file insurance.
Please keep in mind that insurance company percentages are only an estimate and not a guarantee of benefits. Any dispute regarding insurance is your responsibility and not that of our office.

Some insurance companies base the amount of benefits on a chart or schedule of fees arbitrarily developed by third-party payers. For that reason, you may receive lower percentage of the reimbursement level indicated in your dental plan.

Please keep in mind that if you are required to choose a dentist from a list, make sure our office is on it. We only participate with a few. Also, if you can go outside of network with your policy, your insurance may be reduced in our office.

Payment Policies

All payments are due at time of treatment. For your convenience we accept cash, personal checks, Visa, Master Card, Discover and Care Credit.

THERE WILL BE A $25.00 SERVICE CHARGE ON ANY RETURNED CHECKS

You are responsible for all the fees incurred at this office, not your insurance company. You are responsible for all fees incurred at this office including collection fees and court cost. Therefore those charges are as follows: Accounts with broken appointment or late cancellations of appointment will be charged $25.00 for every half hour of their appointment. YOU MUST GIVE A 24 HOUR NOTICE. The charge will have to be paid before we can schedule you another appointment.

HIPPA Policy

Social Circle Dental is completely HIPPA compliant. Our commitment is to our patient's privacy. However, we must divulge some private information in order to file insurance claims, accept payment, confirm, remind of appointments and discuss treatment options. This is not the full disclosure of privacy practice of Social Circle Dental. A full disclosure is available for patients to read in our office.

I have read the above privacy practice of Social Circle Dental. I understand that the full notice of Privacy practice is posted in the office and that I may request a paper copy of the full notice. All of my questions about the privacy of my health information have been answered to my satisfaction.

_____

Signature of patient or responsible party of minor Date