Patient Registration

Patient Demographics

Patient Name: _____

Preferred Name: _____ Today's Date: _____

DOB: _____/_____/_____ SSN: _____ Gender: _____

Address: _____

City: _____ State: _____ Zip: _____

Marital Status: _____ Email Address: _____

Cell Phone: _____ May we text you? _____

Do you need communication assistance? _____

Emergency Contact

Name: _____

Relationship: _____ Phone Number: _____

Referral Information

Were you referred to Patriot Dental by a dental or medical office? _____

If yes, who? _____

If you were not referred, how did you learn about Patriot Dental? _____

Patient Registration

PATRIOT DENTAL

Responsible Party / Guarantor Information

Is the person financially responsible for this account the same as the patient? _____

If not, please complete the section below regarding the **account's guarantor**:

Guarantor Name: _____ Relation to Patient: _____

DOB: _____/_____/_____ SSN: _____ Gender: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Email Address: _____

Insurance Information

Is the policy holder the same as the patient? _____ If yes, skip to next section.

If not, complete the section below regarding the **policy holder**:

Insured Name: _____ Relation to Patient: _____

DOB: _____/_____/_____ SSN: _____ Gender: _____

Address: _____

City: _____ State: _____ Zip: _____

Patient Registration

Insurance Carrier: _____ Effective Date: _____

Insurance Policy ID: _____ Group No: _____

Insurance Company Address: _____

City: _____ State: _____ Zip: _____

Name of Insured's Employer: _____

Appointment Cancellation Policy

Our goal is to provide quality dental care to all our patients in a timely manner. No-shows, late arrivals, and cancellations inconvenience not only our providers, but other patients as well.

When you book your appointment, you are holding a space on our calendar that is no longer available to other patients. We ask that you give our office at least a 48-hour notice if you need to reschedule your appointment. This advanced notice allows our staff to offer your appointment time to other patients in need.

If you miss an appointment without contacting our office with advanced notice, a No Show Fee of $50.00 will be charged to your account. If you arrive for your appointment more than 20 minutes late without advanced notice, this is considered a No Show and the No Show Fee of $50.00 will be charged to your account. This fee cannot be billed to your insurance company and must be resolved before any future appointments can be scheduled.

I have read and understand the Appointment Cancellation Policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time.

Signature: _____ Date: _____

Print Name: _____ Relation to Patient: _____

Patient Registration

PATRIOT DENTAL

Consent to Communication

Patient Name: _____ Today's Date: _____

Do we have permission to leave the following information **on your voicemail**?

☐ Appointment Reminders ☐ Billing Information ☐ Medical/Dental Information

Do we have permission to **text** the following information **to your cell phone**?

☐ Appointment Reminders ☐ Billing Information ☐ Medical/Dental Information

Do we have permission to **mail** the following information **to your home**?

☐ Appointment Reminders ☐ Billing Information ☐ Medical/Dental Information

Do we have permission to send the following information **to your email address**?

☐ Appointment Reminders ☐ Billing Information ☐ Medical/Dental Information

I hereby authorize Patriot Dental to disclose information about me to the following person(s):

Name: _____ Name: _____

Signature: _____ Date: _____

Print Name: _____ Relation to Patient: _____

Witness Signature: _____ Name: _____

Patient Registration

Medical History

Do you have any of the following conditions?

Active Tuberculosis	**Yes / No**
Persistent cough greater than a 3-week duration	**Yes / No**
Cough that produces blood	**Yes / No**
Been exposed to anyone with tuberculosis	**Yes / No**

Are you currently under the care of a physician? _____ If no, skip this section.

Physician Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Are you in good health? **Yes / No**

Has there been any change in your general health in the past year? **Yes / No**

If yes, what condition has been treated? _____

Date of last physical exam: _____/_____/_____ Do you wear contact lenses? **Yes / No**

Have you had a serious illness, operation or been hospitalized in the past 5 years? **Yes / No**

If yes, what was the illness or problem? _____

PATIENT REGISTRATION

Please list all medications you are currently or have recently taken – including prescription, over the counter, vitamins, natural or herbal preparations and/or diet supplements:

_____

_____

_____

Have you had any orthopedic total joint (hip, knee, elbow, finger) replacement? **Yes / No**

If so, date of procedure: _____/_____/_____

Please list any complications you have had: _____

_____

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease? **Yes / No**

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous biphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? **Yes / No**

If so, date treatment began: _____/_____/_____

_____

Do you use controlled substances (drugs)? **Yes / No**

Do you use tobacco (smoking, snuff, chew, bidis)? **Yes / No**

Do you drink alcoholic beverages? **Yes / No**

If yes, how much do you typically drink in a week? _____

PATIENT REGISTRATION

PATRIOT DENTAL

The following section applies to women only:

Are you pregnant? **Yes / No** If so, number of weeks: _____

Taking birth control pills or hormonal replacement? **Yes / No**

Are you currently nursing / breast feeding? **Yes / No**

Allergies

Please circle any of the following that you are allergic to or have had a reaction to:

Local anesthetics
Penicillin or other antibiotics
Sulfa drugs
Metals
Iodine
Animals
Aspirin
Barbiturates, sedatives, or sleeping pills
Codeine or other narcotics
Latex (rubber)
Hay fever/seasonal
Food

If Other, please specify: _____

_____

Congenital Heart Disease (CHD)

Please circle any of the following conditions that you currently have or have had in the past:

Artificial (prosthetic) heart valve
Damaged valves in transplanted heart
Unrepaired, cyanotic CHD
Repaired CHD with residual defects
Previous infective endocarditis
Congenital heart disease (CHD)
Repaired (completely) in the last 6 months

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PATRIOT DENTAL

Other Diseases and Conditions

Please circle any of the following conditions that you currently have or have had in the past:

Cancer/Chemotherapy/Radiation
Angina
Congestive heart failure
Heart attack
Low blood pressure
Other congenital heart defects
Pacemaker
Rheumatic heart disease
Blood transfusion (Date: _____/_____/_____)
Hemophilia
Arthritis
Rheumatoid arthritis
Asthma
Emphysema
Tuberculosis
Chronic pain
Eating disorder
Gastrointestinal disease
G.E. Reflux/persistent heartburn
Glaucoma
Epilepsy / fainting / seizures
Kidney problems
Osteoporosis
Severe headaches/migraines
Sexually transmitted disease

Cardiovascular disease
Arteriosclerosis
Damaged heart valves
Heart murmur
High blood pressure
Mitral valve prolapse
Rheumatic fever
Abnormal bleeding
Anemia
AIDS or HIV
Autoimmune disease
Systemic lupus erythematosus
Bronchitis
Sinus trouble
Chest pain upon exertion
Diabetes Type I or II
Malnutrition
Thyroid problems
Stroke
Hepatitis, jaundice or liver disease
Sleep disorder
Night sweats
Persistent swollen glands in neck
Severe or rapid weight loss
Excessive urination

Patient Registration

Neurological disorders If yes, please specify: _____

Mental health disorders If yes, please specify: _____

Recurrent infections Type of infection: _____

Premedication

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? If so, please provide the name and phone number of physician / dentist:

_____

Do you have any disease, condition, or problem not listed above that you think I should know about? _____ If so, please explain: _____

_____

Dental History

Have you been satisfied with your previous dental care? **Yes / No**

Do you have discomfort in your mouth now? **Yes / No**

How long has it been since your last dental visit? _____

Do your gums bleed, feel tender or irritated? **Yes / No**

Are your teeth sensitive to hot / cold / sweets? **Yes / No**

When you smile in the mirror are you happy with the way your teeth look? **Yes / No**

If not, please explain: _____

Do you feel your teeth are in alignment (straight)? **Yes / No**

If not, please explain: _____

Patient Registration

Do you have spaces that you don't like? **Yes / No**

If yes, please explain: _____

Do you like the color of your teeth? **Yes / No**

If not, please explain: _____

Do you like the shape of your teeth? **Yes / No**

If not, please explain: _____

Do you like the way your teeth come together? **Yes / No**

If not, please explain: _____

Please circle any of the following that apply – are your teeth? **Chipped / Protruding / Hidden**

Are there any old fillings or dental work that you don't like looking at? **Yes / No**

If yes, please explain: _____

What would you like to change most in the appearance of your teeth? _____

_____

_____

_____

Patient / Guardian Signature: _____ Date: _____

Relation to Patient, if not signed by patient: _____

PATIENT REGISTRATION

Terms and Conditions of Service

In consideration of all services provided by Pensacola Patriot Dental, PLLC, and its affiliated dental practices doing business as Patriot Dental and their employees and contractors, and its affiliated dental practices and their employees and contractors (individually and collectively, the "Dental Group"), the undersigned hereby acknowledges and agrees on behalf of himself or herself, and on behalf of his or her children, dependents, and other persons for whom he or she serves as guarantor (collectively, "Dependents"), with the following terms and conditions of service:

Medical Information. The undersigned hereby certifies that all information provided to the Dental Group is true, correct and complete and agrees to promptly inform the Dental Group of any changes in any information (including regarding any Dependent). The Dental Group is authorized to use and disclose to any insurance, billing, management or processing company, agency or organization any health care information and medical records relating to the undersigned or any Dependent to obtain payment for services, determine insurance benefits, or otherwise as required by law. The Dental Group is authorized to contact the undersigned at any telephone number provided above (unless otherwise revoked in writing) to discuss this form and any billing, treatment, or other matter related to any dental treatment (including for any Dependent).

Treatment; Informed Consent. The undersigned authorizes the Dental Group and any treating dentist, hygienist, and staff member to perform all treatment described in any treatment plan (and including all other services determined by such dentist to be necessary or appropriate in connection with such treatment plan) accepted by undersigned for himself or herself or any Dependent. Dentistry is a biological procedure and not an exact science; therefore, despite the highest standard of care, no guarantee is or can be given by the Dental Group or any dentist or any other person employed or contracted by the Dental Group regarding any treatment or the results that may be obtained. The patient must comply with all specified appointments, procedures, and continuing care, and failure to do so will adversely affect the patient's treatment often necessitating additional required treatment (or retreatment) with additional fees. Failure to show within 20 minutes of the scheduled time for, or provide at least 48 hours advance notice of cancellation of, any appointment for any reason will result in a No Show Fee of $50. Patriot Dental does not exercise control over the professional services of any of its treating dentists; therefore, the undersigned shall solely hold the treating dentist responsible for any treatment performed (including, without limitation, treatment provided under the treating dentist's supervision) and agrees to hold harmless Patriot Dental and its interest holders, members, managers, officers, owners, affiliates, employees, agents, contractors, and all other persons and entities under common control or ownership with the Patriot Dental. Fees in treatment plans for noninsurance/discount plan patients are only valid for 30 days; all insurance/discount plan fees are subject to change at any time based upon changes in plan fee schedules or to correct errors.

Financial Responsibility; Insurance. THE UNDERSIGNED PATIENT AND GUARANTOR ASSUME FULL RESPONSIBILITY FOR PAYMENT OF ALL FEES AND CHARGES FOR ALL SERVICES OF THE DENTAL GROUP, WHETHER OR NOT COVERED BY INSURANCE. THE PATIENT'S PORTION OF ALL FEES (INCLUDING ALL DEDUCTIBLES AND CO-PAYS) IS DUE AND PAYABLE IN FULL AT THE TIME SERVICES ARE PERFORMED. For treatment involving multiple appointments, such as a crown, root canal, denture, or implant, the entire patient portion is normally due when treatment is started. Any special financial arrangements must be made before treatment is started. All insurance, discount plans and discount coupons must be presented before treatment is started. The Dental Group submits insurance claims solely to primary dental insurance for patients' convenience and does not assume responsibility for the processing of such insurance or failure of insurance to pay for any reason. Dental insurance rarely covers all fees; estimated or preauthorized insurance benefits are not guaranteed. The undersigned agrees to pay promptly on demand any balance not paid by insurance within 60 days after the date of service. A service charge of 1½% per month (18% per annum) is charged on all balances more than 30 days past due. Insurance balances are considered past due if not paid within 60 days of the date of service. The undersigned shall pay all costs incurred by the Dental Group relating to collection of any unpaid or delinquent balance (including, without limitation, attorneys and

collection agency fees, court costs, paralegals) whether or not suit is filed. The Dental Group reserves the right to terminate or deny any treatment if the patient's account is delinquent.

Assignment of Benefits; Authorization and Release. The undersigned hereby certifies that all insurance coverage described above is current and valid and assigns directly to the Dental Group all insurance benefits covering the undersigned or any Dependent for all services rendered. The undersigned hereby agrees that his or her signature below will be maintained "on file"; the Dental Group is authorized to use such signature on all applicable insurance claims and submissions. If any insurance payment is made to the undersigned, he or she shall immediately remit such payment to the Dental Group.

Notice of Privacy Practices. The undersigned has reviewed a copy of the Dental Group's Notice of Privacy Practices effective September 3rd, 2021, as amended.

I have read the above terms and conditions of service by the Dental Group and understand and accept such terms:

Signature: _____ Date: _____

Print Name: _____ Relation to Patient: _____