TURLOCK
FAMILY
DENTISTRY

3950 Geer Rd., Turlock, CA 95382
Phone: (209) 668-4013

PATIENT REGISTRATION (Adult)

Patient Name: _____

Address: _____ P.O. Box: _____

City: _____ State: _____ Zip: _____

☐ Male ☐ Female Age: _____ Nickname: _____ Referred By: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Do we have your permission to leave a message on voice mail or recorder? Initial Here _____

Birth Date: _____ Social Security# _____ Driver's Lic.# _____

Occupation: _____ How Long? _____

Employer: _____ Employer Phone # : _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Marital Status: Single ☐ Married ☐ Divorced ☐ Separated ☐ Other ☐

Spouse Name: _____

Address: _____ P.O. Box: _____

City: _____ State: _____ Zip: _____ AGE: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Birth Date: _____ Social Security# _____ Driver's Lic.# _____

Occupation: _____ How Long? _____

Employer: _____ Employer Phone # : _____

Employer Address: _____ City: _____ State: _____ Zip: _____

In case of emergency, please notify my nearest relative or acquaintance not living with me.

Name: _____

Address: _____

Phone: _____ Relationship: _____

1. Are you having pain or discomfort at this time?_____ YES NO
2. Have you been under the care of a medical doctor during the past two years?_____ YES NO

   Physician's Name_____

   Address _____ Telephone_____
3. Are you now taking any medication, drugs or pills?_____ YES NO

   If yes, please list:_____
4. Are you aware of being allergic to or have you ever reacted adversely to any medication or substance?_____ YES NO

   If yes, please list:_____
5. Indicate which of the following you have had or have at present. Please circle and provide date.

Heart Failure	YES	NO	Stroke	YES	NO	Hepatitis A (infectious)	YES	NO
Heart Disease	YES	NO	Artificial Joints (hip, knee, etc.)	YES	NO	Hepatitis B (serum)	YES	NO
Heart Attack	YES	NO	Kidney Trouble	YES	NO	Venereal Disease	YES	NO
Angina Pectoris	YES	NO	Ulcers	YES	NO	A.I.D.S.	YES	NO
Congenital Heart Disease	YES	NO	Diabetes	YES	NO	H.I.V. Positive	YES	NO
Heart Murmur	YES	NO	Thyroid Problems	YES	NO	Cold Sores/Fever Blisters	YES	NO
High Blood Pressure	YES	NO	Glaucoma	YES	NO	Blood Transfusion	YES	NO
Arteriosclerosis	YES	NO	Cosmetic Surgery	YES	NO	Hemophilia	YES	NO
Mitral Valve Prolapse	YES	NO	Emphysema	YES	NO	Anemia	YES	NO
Artificial Heart Valve	YES	NO	Chronic Cough	YES	NO	Sickle Cell Disease	YES	NO
Heart Pacemaker	YES	NO	Tuberculosis	YES	NO	Bruise Easily	YES	NO
Heart Surgery	YES	NO	Asthma	YES	NO	Liver Disease	YES	NO
Rheumatic Fever	YES	NO	Allergy to Latex	YES	NO	Yellow Jaundice	YES	NO
Arthritis	YES	NO	Allergies or Hives	YES	NO	Epilepsy or Seizures	YES	NO
Rheumatism	YES	NO	Sinus Trouble	YES	NO	Fainting or Dizzy Spells	YES	NO
Pain in Jaw Joints	YES	NO	Radiation Therapy	YES	NO	Phen-Fen	YES	NO
Cortisone Medicine	YES	NO	Chemotherapy	YES	NO	Psychiatric Treatment	YES	NO
						Drug Addiction	YES	NO

6. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired?_____ YES NO
7. Do your ankles swell during the day?_____ YES NO
8. Do you use more than two pillows to sleep?_____ YES NO
9. Have you lost or gained more than 10 pounds in the past year?_____ YES NO
10. Do you ever wake up from sleep and feel short of breath? _____ YES NO
11. Are you on a special diet? _____ YES NO
12. Has your medical doctor ever said you have a cancer or tumor? _____ YES NO
13. Do you have or have you had any disease, condition, or problem not listed?_____ YES NO

    If yes, please list:_____

FOR WOMEN ONLY:

Are you pregnant? ☐ Yes, what month?_____ ☐No Are you nursing? ☐Yes ☐No Are you taking birth control pills ☐Yes ☐No

I understand the above infomation is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature_____ Date_____

CONSENT:

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (name of patient)_____ and further authorize and consent that Doctor choose and employ such assistance as deemed fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 1½% finance charge (19% annually) will be added to any balance over 60 days. In the event of default I (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Patient_____ Date_____ Witness_____

Parent or Responsible Party._____ Relationship to Patient___ _____

Welcome to our practice. Our goal is to provide you with the best in dental care for many years. Please take time to answer these questions. Your answers will help us ensure we become the best, while we work with you to create your healthy and beautiful smile.

1. What is the reason for today's visit?

2. How would you describe your dental experiences, as an adult, over the past 10 + years?

3. What did you like most about any dental office you have been seen in?

4. What did you like least about any dental office you have been seen in?

5. When you brush or floss your teeth have you ever noticed any blood in your mouth, on your toothbrush or dental floss? YES NO

6. Have you ever been treated for gum disease before? YES NO

7. Do you have any concerns regarding your breath? YES NO

8. Do you expect to keep your teeth for a lifetime? YES NO

9. When you schedule a dental appointment, do you feel so anxious that you are unable to keep the appointment? YES NO

10. If there were a simple way to whiten your teeth, would you be interested? YES NO

11. On a scale of 1 to 10 how would you rate your smile?

12. If you could have wave a magic wand and change one thing about your SMILE to make it a 10 what would it be?

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I, _____, hereby authorize **Turlock Family Dentistry** to discuss
(Name of patient)

And/or release any and all of my Dental health information and financial obligations:

To: _____

Relationship: _____

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I understand that by signing this authorization:

- I authorize the use or disclosure of my individually identifiable health information as described above for the purpose listed.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke that authorization at any time. The revocation must be made in writing and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I am signing this authorization voluntarily and treatment, payment, or my eligibility for benefits will not be affected if I do not sign this authorization.
- I further understand that a person to whom records and information are disclosed pursuant to this authorization may not further use or disclose the medical information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

_____ _____

Signature of the Individual Giving this Authorization Date

TURLOCK FAMILY DENTISTRY

FINANCIAL POLICY

This statement is to inform you of our financial policy. We are committed to providing you with the highest quality dental care using only the best material and technology available in the market today. We are also committed to providing you with up-to-date information and educational tools so that you may fully participate in maintaining optimum oral health. Our financial policy is intended to facilitate excellent service to you while minimizing our administrative costs.

All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and the insurance company. Our office is not a party to that contract. If payment from your insurance company is not received within 60 days from date of service, you will be expected to pay the balance in full.

As a courtesy to you we will help you process all your insurance claims. You may direct your insurance company to pay your benefits directly to our office by signing the authorization on the Assignment of Benefits Agreement. In order for our office to file your insurance claim, you must bring a completed dental insurance form or proof of insurance at each appointment.

Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, American Express and Discover. Outside financing is available through CareCredit upon request and approval.

Returned checks and balances older than 60 days may be subject to collection fees and finance charges at the rate of 1.5% per month (18% annually). Additionally, our office will charge you for broken appointments and appointments cancelled without 48-hour advance notice.

If you have any questions regarding our financial policy, please ask. We are committed to providing you with the most positive experience in dental care.

_____

Print Name

_____ _____

Signature Date

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TURLOCK FAMILY DENTISTRY

ASSIGNMENT OF BENEFITS AGREEMENT

Our office will accept an assignment of benefits from your insurance company with the following provisions. It is important to understand, though, that the contract regarding your dental benefits is between you, your employer, and your insurance company. The obligation you have with our practice is to pay for treatment, regardless of the amount that may or may not be reimbursed by your insurance company. The following provisions identify our policies governing insurance claims.

- Although we are willing to complete insurance information forms and submit a claim on your behalf, we do not accept responsibility for the outcome of the transaction. Completing insurance forms is a courtesy we extend to you in an effort to maximize your insurance reimbursement. By having our office process your insurance forms, it is important that you understand that this does not eliminate your financial obligation for your treatment.
- We require you to sign this form and/or any other necessary assignment documents that may be required by your insurance company. This instructs your insurance company to make payment directly to our office.
- We require you to pay the co-payment, which is the amount not covered by your insurance company, at the time we provide service to you.
- Insurance payments ordinarily are received within 30-60 days from the time of billing. If your insurance company has not made payment to our office within 60 days, we will ask you to pay the balance due at that time. You will be responsible for seeking reimbursements from your insurance company at that time.
- Our office does not guarantee that your insurance company will pay for treatment you receive from our practice. We perform routine insurance billing procedures upon verification of coverage. However, if your claim is denied, you will be responsible for paying the full amount at that time.
- Our office will not enter into a dispute with your insurance company over any claim, although we will provide necessary documentation your insurance company requests to sort out any confusion or questions that may arise. We will cooperate fully with the regulations and requests of your insurance company. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company.

I HAVE READ AND UNDERSTAND THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO THE DOCTOR.

I AUTHORIZE YOU TO DEBIT MY CREDIT CARD IF YOU HAVE NOT RECEIVED PAYMENT FROM MY INSURANCE COMPANY WITHIN 60 DAYS OF RECEIVING TREATMENT.

Print Name _____ Credit Card Number _____ Expiration Date _____

Signature _____ Date _____

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Insurance Benefits

As a courtesy, we will verify your insurance coverage and benefit information with your Insurance Company.

Turlock Family Dentistry is not responsible if incorrect benefit information is given to us by your insurance carrier, or any changes in coverage after the date of verification.

It is ultimately your responsibility to know your benefits and coverage.
It is recommended you call your insurance company to verify any benefits quoted.

In the event of non-payment by your insurance company any accrued charges are your responsibility.

Acknowledgment of Receipt of Privacy Practices

I have received a copy of Turlock Family Dentistry's Notice of Privacy Practices with an effective date of April 14, 2003.

Signature_____ Date_____

Acknowledgment of Dental Materials Fact Sheet

I have received a copy of Dental Materials Fact Sheet as required by law.

Signature_____ Date_____

Your Appointments & Cancellation Policy

We know that your time is valuable and our practice is committed to making sure that you are seen on time for your appointment.

A scheduled appointment is a commitment of time between you and our practice. We have reserved that time exclusively to provide the recommended treatment for you. We ask that when you schedule an appointment that you make every effort to keep that commitment. We understand that personal emergencies do sometimes occur; and we always take that into consideration when receiving a last minute cancellation.

If you find that you cannot keep your scheduled appointment time, please provide our office with two, (2), working days notice to avoid being charged a cancellation fee with can be up to $50.00 per hour of chair time.

Our appointment administrators can take care of your rescheduling needs.

For your convenience we have a 24 hour answering service available.

We sincerely appreciate your understanding and cooperation with this matter.