Patient Registration Form

PATIENT INFORMATION

Patient name: _____ Date of birth: _____ Sex: _____ Age: _____

Home address: _____ City: _____ State: _____ Zip: _____

Billing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ E-mail: _____

SS#: _____ Employer/Occupation: _____ Work Phone: _____

Preferred Contact Method (please circle): Email Cell Text Home Work

Emergency Contact: _____ Relation: _____ Phone: _____

How did you hear about us? _____

RESPONSIBLE PARTY

Person Responsible for this Account: _____ Relation: _____

Address: _____

Employer: _____

DENTAL INSURANCE INFORMATION

Do you have dental insurance? (if answering yes, please complete the following info) Yes No

Primary dental insurance: _____ Group #: _____

Subscriber's name: _____ Date of birth: _____ SS#: _____

Secondary dental insurance: _____ Group #: _____

Subscriber's name: _____ Date of birth: _____ SS#: _____

Financial Policy of Vecchio and Vecchio DDS

We understand that dental care can sometimes be an unexpected expense. We have in place several methods which allow our patients to undergo treatment in a timely manner while still fulfilling their financial obligations. Our financial policy is as follows...

Co-payment, if required by your insurance, is due upon arrival of your appointment. You are responsible for payment at the time of services unless prior arrangements have been made, including the billing of your insurance. We accept cash, checks, Mastercard, Visa, and Discover. We also accept Care Credit (0% interest payment plan).

We accept most insurances (please call ahead to see if we accept yours). Please review your insurance benefits before calling our office. Many times, you will find the answer to your question in the benefits handbook sent to you by your insurance company. You are responsible for all charges for services rendered, but as a courtesy, we will bill your insurances and will collect payment from your insurance upon you assigning benefits to our office. You are responsible for any deductibles and may be responsible for any remaining balances once we receive payment from your insurance. A statement will be sent to you in this case. If you have any questions regarding this bill, you may contact our office at 440-365-9580.

Dental insurance is far different from medical insurance and carries with it restrictions and maximums. Please know your benefits before your appointment.

If you fail to pay your bill after 3 attempts to collect payment from you, you will either be notified by our attorney or be turned over to collections. In the event your account is turned over to collections, a $25.00 service fee will be added to your balance. Also, any fees incurred if your account is placed for collections, including any legal and/or collections fees, will be your responsibility. If you have difficulty making your share of the payment, please contact our office immediately so we can work with you on a payment plan that is agreeable to both parties. If a check is written and the same check is returned to us twice for insufficient funds, we will attempt to reach you. If we are unsuccessful or a payment arrangement is not made within 10 days of our initial attempt to reach you, the check will be turned over to collections and a $25.00 service fee will be added to the balance.

Membership in an insurance plan does not guarantee coverage for all procedures. You will be responsible for any fee not covered by insurance. Please be aware of the full cost of treatment before scheduling.

X_____ (sign and print your name below)

Please Note: Every effort will be made to help you with your insurance. However, if your insurance does not pay as expected you will still be responsible for the balance. This is a legal and binding contract.

Patient Name: _____

MEDICATIONS

Please list all current medications, dosage and reason for taking them:

_____

_____

_____

_____

_____

_____

_____

_____

_____

ALLERGIES

Are you allergic to or have you had a reaction to any of the following (please circle):

Latex	Anesthetic	Aspirin
Codeine	Penicillin	Metals
Sulfa Drugs	Animals	Food

Reaction: _____

Other Allergies: _____

MEDICAL HISTORY

Are you under the care of a physician? ☐YES ☐NO

Have you ever been hospitalized? ☐YES ☐NO

Reason? _____

Are you pregnant/nursing? ☐YES ☐NO

Have you ever, or do you now use controlled substances? ☐YES ☐NO

Do you use tobacco products? ☐YES ☐NO

Please check if you have, or have had any of the following medical conditions:

☐Heart Disease	☐Heart Attack
☐Mitral Valve Prolapse	☐Pacemaker
☐Artificial Heart Valve	☐Stents
☐High Blood Pressure	☐Chest Pain
☐Low Blood Pressure	☐Cancer
☐Heart Murmur	☐Diabetes
☐Artificial Joints	☐Asthma
☐Chemo/Radiation	☐Blood Disease
☐Shortness of Breath	☐Emphysema
☐Epilepsy/Seizures	☐Osteoporosis
☐Abnormal Bleeding	☐COPD
☐Fainting/Dizziness	☐Hemophilia
☐Hepatitis A, B, or C	☐HIV/AIDS
☐Hypoglycemia	☐Leukemia
☐Kidney Problems	☐Shingles
☐Rheumatic Fever	☐Arthritis
☐Sleep Apnea	☐Sinus Trouble
☐Multiple Sclerosis	☐Tuberculosis
☐Thyroid Disease	☐Ulcers
☐Venereal Disease	☐Glaucoma
☐Frequent Cough	☐Anemia
☐Mental Health Disorder	☐Stroke
☐High Cholesterol	☐Anxiety

Other Medical Conditions Not Listed: _____

_____

_____

_____

Sign: _____

Date: _____

DENTAL HISTORY

What is the reason for your dental visit today?

_____

_____

Are you apprehensive about dental treatment?

☐YES ☐NO

Are you experiencing dental pain now?

☐YES ☐NO

If so, where?

_____

Is the pain associated with (please circle).....

Cold Hot Sweets Pressure

Do you have difficulty chewing your food?

☐YES ☐NO

Does your breath concern you?

☐YES ☐NO

Do your gums bleed when your brush or floss?

☐YES ☐NO

Have you ever been diagnosed with periodontal (gum) disease?

☐YES ☐NO

Do you have a family history of gum disease?

☐YES ☐NO

Is your home water supply fluoridated?

☐YES ☐NO

Do you drink tap water or bottled/filtered water? How often?

_____

Have you ever had orthodontic (braces) treatment?

☐YES ☐NO

Do you have sores or ulcers in your mouth?

☐YES ☐NO

If you use tobacco products, what type do you use and how often?

_____

Do you experience dry mouth?

☐YES ☐NO

How many times a day do you brush your teeth? _____

How often are you flossing? _____

Do you clench or grind your teeth?

☐YES ☐NO

Does your jaw hurt when you chew or open it wide to take a bite?

☐YES ☐NO

Has any medical doctor advised you take a pre-medication prior to dental care?

☐YES ☐NO

Do you wear any type of retainer, night-guard or removable oral appliance (partial/denture)?

☐YES ☐NO

If yes, please describe: _____

Date of last dental exam: _____

What was done at that time? _____

_____

Date of last dental x-rays: _____

How do you feel about your smile? _____

_____

_____