New Patient Welcome

Patient Registration

We take your oral health very seriously. Before we begin your appointment, we need some information.
All information is confidential.

First: _____ Middle: _____ Last: _____
Preferred Name: _____ Today's Date: _____
Patient Social Security Number: _____ Patient Date of Birth: _____ Sex: (circle) M F

Street: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
Email Address: _____

Employer: _____ Length of employment: _____
Occupation: _____ Work Phone: _____
Are you a full time Student? (circle) Yes No
If yes, we need: Mother's DOB: _____
Father's DOB: _____
Preferred Pharmacy: _____

Emergency Contact: _____ Phone: _____
Address: _____

Reason for this visit? _____

How did you hear about us?

◯ Family Member: _____ ◯ Insurance: _____
◯ School/Daycare: _____ ◯ Friend: _____
◯ Pediatrician/Physician: _____ ◯ Event: _____
Internet: Print Ad:
◯ Google ◯ Website ◯ Facebook/Instagram ◯ Angie's List ◯ Phone Book ◯ Magazine ◯ Mailer
Other: _____

Do you have Dental Insurance? Yes No

Insured's Name:	Insured's Name:
Insured's SSN#:	Insured's SSN#:
Insured's DOB:	Insured's DOB:
Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other	Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other
Insured Employer:	Insured Employer:
Insurance Company:	Insurance Company:
Ins. Co. Address:	Ins. Co. Address:
Insurance Phone #:	Insurance Phone #:
Insurance Group #: Insurance Local #:	Insurance Group #: Insurance Local #:

Do you have Secondary Dental Insurance? Yes No

Health History

We take your oral health very seriously. But before we start your treatment, we need some brief information on your medical history which may affect your treatment. All information is confidential.
Patient's Name: _____Date of Birth: _____
Reason for today's visit? _____

List any medications you are allergic to
1. _____ 2. _____
3. _____ 4. _____

List any medications you are taking including Non-prescription drugs and herbals/vitamins:
1. _____ 2. _____
3. _____ 4. _____

Dental History - Please mark (x) any of the following conditions that apply to you

Periodontal (Gum) Health
__Bleeding, Swollen, Irritated gums
__Bad breath
__shifting teeth
__Previous perio/gum disease

Pain/Discomfort
__Sensitivity (hot, cold, sweet)
__Pressure
__Broken teeth/fillings
__Dry Mouth

Function
__Grinding/Clenching
__Headaches
__Jaw Joint (TMJ) pain
__Jaw Joint (TMJ) clicking/popping
__Mouth Breathing
__Sore Muscles (neck, shoulders)
__Difficulty Opening or Closing
__Difficulty Chewing on either side

Appearance
__Discolored teeth
__Worn teeth
__
__Spaces
__Overbite
__Flat teeth

Sleep Pattern or Conditions
__Sleep Apnea
__Snoring
__Daytime Drowsiness
__Bed wetting (for children)

Social
__Tobacco:
How much__ How long_____

Medical History - please mark (x) to indicate if you have or have had any of the following

Cardiovascular
__Angina (chest pain)
__Artificial Heart Valve
__Heart Conditions
__Heart Surgery
__High/Low Blood Pressure
__Mitral Valve Prolapse
__Pacemaker
__Rheumatic Fever
__Scarlet Fever
__Stroke

Cancer: Type _____
__Chemotherapy
__Radiation Therapy

Endocrinology
__Diabetes
__Hepatitis A/B/C
__Jaundice
__Kidney Disease
__Liver Disease
__Thyroid Disease

Gastrointestinal
__Ulcers (Stomach)
__Gastrointestinal Disease

Viral Infections
__AIDS
__HIV Positive
__HPV

Respiratory
__Asthma
__Emphysema
__Respiratory Problems
__Sinus Problems
__Sleep Apnea
__Tuberculosis

Hematologic/Lymphatic
__Anemia
__Blood Disorders
__Bruise Easily
__Excessive Bleeding

Women
__Currently Pregnant
__Nursing
Is there a possible pregnancy? Y N
Estimated delivery Date:___/___/___
Are you nursing? Y N
Are you taking birth control? Y N

Musculoskeletal
__Arthritis
__Artificial Joints
__Jaw Joint Pain
__Rheumatoid Arthritis

Neurological
__Anxiety
__Depression
__Dizziness
__Drug/Alcohol Addiction
__Fainting
__Seizures
__Psychiatric Illness

*NOTE: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician for additional methods of birth control.

Patient/Guardian Signature_____ Date_____ Reviewed by_____ Date____

Consent & Financial Policy

I authorize the disclosure of information from my treatment records to:
Name of Recipient: _____
Relationship to the Patient: _____

I give authorization to disclose the following information:

- ☐ All treatment information
- ☐ Information specifically related to these treatment dates

Starting Date: _____ End Date: _____

I understand that I may withdraw or revoke my permission at any time. I may revoke this authorization by notifying my Magnolia Dental practice in writing.

Signature of Patient (or Patient Representative) _____ Date: _____
Printed Name of Patient (or Patient Representative) _____

Financial Policy

Thank you for choosing our office as your dental health care provider. We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment. Payment is due at the time service is provided.

Our office accepts cash, personal checks, credit cards and outside patient financing.

Please check if you would like more information about financing options._____

Please Note: Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance; you will be responsible for any collection and/or legal charges up to 35%.

Do You Have Insurance?

- 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 your insurance company.
- As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an **insurance estimate** to you, however, it is not a guarantee that your insurance will pay exactly as estimated. **Your insurance company and your plan benefits will determine the amount paid**. We will, of course, do all we can to make sure your estimate is as accurate as possible. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office. Please keep your insurance information current by notifying us of any changes in employment and insurance coverage.
- We ask that you pay the deductible and co-payment, which is the estimated amount, not covered by your insurance company, by cash, check, credit card or Patient Financing at the time we provide the service to you.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

Twenty-four hour notice is required when re-scheduling or canceling an appointment.
A cancellation fee of $45.00 may be assessed for broken appointments with less than twenty-four hours notice

We thank you for the opportunity to serve your dental health care needs and welcome any question you may have concerning your care or our financial policy.

Authorization

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize the release of any information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I authorize the release of any information concerning my (or my child's) health care, advice and treatment to another dentist. I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me. I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payments of services not paid, in whole or in part by my dental care payer. I attest to the accuracy of the information on this page.

Patient Signature (Parent if child)_____ Date _____

Patient Satisfaction

We are committed to providing you with exceptional service and care. If you feel you have an issue that cannot be resolved by your office team, please email us at HR@mymagnoliasmile.com

Financial Policy

Please visit our website at www.mymagnoliasmile.com to view our full financial policy.