Patient Registration

Date:_____ Last Name:_____ First, MI:_____ Age:_____ DOB:_____

Home Phone: ( )_____ Work Phone: ( )_____ Cell Phone: ( )_____ Sex:_____

Address:_____ State:_____ Zip Code:_____ Social Security #_____

Driver's License #:_____ State:_____ Marital Status:_____

Employer & Address:_____ Occupation:_____

Dental Insurance Co: _____ Group #:_____

Spouse Name:_____ DOB:_____ Social Security # of Spouse:_____

Spouse's Employer & Address:_____ Occupation:_____

Spouse's Business Phone:_____ Spouse's Cell Phone:_____

Spouse's Dental Insurance:_____ Spouse's Group #:_____

Who is responsible for this account? _____ Who can we thank for referring you? _____

Name and Address of relative not living with you: _____

Relative's Telephone # _____

Who should be contacted in cases of emergency?_____ Phone #'s:_____

Authorization

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment, including the portion not paid by insurance. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic, radiographic and therapeutic procedures as may be necessary for dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals.

Method of Payment

Does the responsible party currently have an account with this office?

◯ Yes ◯ No

Please select payment type for services rendered:

Cash ◯ Check ◯ Visa ◯ MC ◉

Payment Policy

Payment is due when treatment is started. If you have dental insurance an estimate of your co-pay can be provided. The estimate is not a guarantee of what the insurance company will provide. Patients are financially responsible for their portion of treatment (what is not covered by dental insurance).

Dental Insurance

It is the patient's/responsible party's ultimate responsibility to understand their dental insurance policy. This includes but is not limited to definition of benefits, exclusions, Rewaiting periods, provider status, knowing what insurance the patient has and if it is active, and treatment limitations. We will do our best to research and help answer any questions you have about your policy.

Service Charge

If the responsible party does not pay the entire new balance within 90 days, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of 1.5% per month (18% annual) with a minimum of $3.00 for a balance under $200. In the case of default of payment, the responsible party will pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

Broken Appointments

It is the responsible party's responsibility to be on time for all scheduled appointments. A minimum of 24hrs. notice is required if an appointment needs to be rescheduled or cancelled. **Failure to give sufficient (24hrs+) notice will result in a $35 broken appointment fee.**

I have read the above authorization, method of payment, payment policy, dental insurance, broken appointment and service charge policies and understand it. All information I have given is accurate.

X_____ Date:_____

Health Questionnaire

Guy Sutton DDS

Yes No

1. Is your general health good?
2. Has there been a recent change in health?
3. Have you been hospitalized/seriously ill in the last year?
4. Are you being treated by a Physician now?
   For what? _____
5. Date of last Medical Exam _____
6. Physician's Name, phone # _____
7. Have you had problems with prior Dental treatment?
8. Are you in pain now?

Dental History-

Date of last dental exam _____

When was your last dental cleaning? _____

Do your gums bleed? Yes No _____

Do you floss regularly?

Have you ever been diagnosed with gum disease?

Have you had Orthodontics (braces)?

Would you like to improve your smile?

Have you previously whitened your teeth?

Have you/do you have "TMJ"- jaw pain?

Have you recently experienced-

9. Chest pain (angina)?
10. Shortness of breath?
11. Recent unintentional weight loss?
12. Fever, night sweats?
13. Persistent cough?
14. Bleeding problems?
15. Bruise easily?
16. Mitral Valve Prolapse?
17. Sinus problems/ seasonal allergies?
18. Difficulty swallowing?
19. Diarrhea/blood in stool?

Do you have or have you had?

20. Frequent Nausea/Vomiting?
21. Difficulty urinating/blood in urine?
22. Dizziness/Ringing in the Ears?
23. Cold sores/Herpes virus?
24. Headaches? Migraine Tension Cluster
25. Fainting spells?
26. Seizures?
27. Excessive thirst?
28. Dry mouth?
29. Jaundice?
30. Joint pain/arthritis?
32. Heart disease?
33. Heart Attack/myocardial infarction?
34. Heart defect?
35. Rheumatic Fever?
36. Stroke?
37. Hardening of arteries?
38. High Blood Pressure?
39. Taken Fen/Phen?
40. Hepatitis? A B C other
41. Tuberculosis+ or Lung Disease?
42. Stomach problems, GERD, Ulcers?
43. Eye disease?
44. Skin disease?
45. Osteoporosis?
46. Thyroid, adrenal disease.
47. Anemia?
48. Venereal disease?
49. AIDS or ARC?
50. Tumors or Cancer?
51. Arthritis, Rheumatism?
52. Kidney, bladder disease?
53. Diabetes? I, II
54. Psychiatric care?
55. Hospitalization?
56. Radiation Treatment?
57. Prosthetic Heart Valve/Artificial Joint?
58. Chemotherapy?
59. Surgery? _____
60. Pacemaker?
61. Blood transfusions?
62. Are you pregnant or nursing?
63. Do you use- **Tobacco?**
64. Do you use- **Alcohol?**
65. Do you use- **Recreational Drugs**?
66. Have you taken **Bisphosphonates** (Fosamax, Actonel, Boniva)?

Drug Allergies: ☐ Penicillin ☐ Codiene ☐ Sulfa ☐ Latex

Other: _____

_____

Food Allergies: _____

List your Medications: _____

Patient Signature: _____ **Date:** _____ **Reviewed by:** _____

Patient Signature: _____ Date: _____ Reviewed by: _____

Patient Signature: _____ Date: _____ Reviewed by: _____

Patient Signature: _____ Date: _____ Reviewed by: _____