waterstone DENTISTRY

New Patient Registration

Patient Information (Confidential)

Name: _____ Preferred Name _____

Address : _____
(Street) (City) (State) (Zip)

Home #: _____ Work: _____ Cell: _____ E-Mail: _____

Marital Status: Single ____ Married ____ Divorced ____ Widowed ____ Other _____

Date of Birth: _____ SS #: _____ Previous Dentist: _____

Emergency Contact: _____ Phone #: _____

Pharmacy: _____ Phone #: _____

How did you hear about our office? _____

Responsible Party (do not fill out if same as above)

Person responsible for Patient: _____ Relationship to Pt: _____

Address : _____
(Street) (City) (State) (Zip)

Home #: _____ Cell _____ Work _____ E-Mail _____

Insurance Information (Please provide copy of card)

Name of Insurance Company: _____

Name of Insured: _____ Relationship to Pt: _____

Name of Employer: _____ DOB: _____ SS#: _____

Secondary Insurance (if applicable)

Name of Insurance Company: _____

Name of insured: _____ Relationship to Pt: _____

Name of Employer: _____ DOB: _____ SS#: _____

Patient Signature: _____ **Date:** _____

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Personal Dental History

NAME: _____ Date: _____

Purpose of today's visit:

_____

_____

Are you experiencing any discomfort in your mouth at this time?

_____

_____

If yes, have you consulted with any other dentist about this? Yes ____ No ____

If yes, what was discussed or done?

_____

_____

When was your last dental cleaning & check-up?

_____

Do you have or have you ever had any of the following:

Gum disease (gingivitis)	Yes ___ No ___	Food collection between teeth		Yes ___ No ___
Grind your teeth	Yes ___ No ___	Sores, blisters, growths		Yes ___ No ___
Clicking or popping jaw	Yes ___ No ___	Bad breath		Yes ___ No ___
Jaw pain or tiredness	Yes ___ No ___	Sensitivity to:	Cold	Yes ___ No ___
Pain around ear	Yes ___ No ___		Heat	Yes ___ No ___
Lip or cheek biting	Yes ___ No ___		Sweets	Yes ___ No ___
Loose/broken teeth or fillings	Yes ___ No ___		Biting/Chewing	Yes ___ No ___

Would you like to know what options are available to you to?

1) Create a more attractive smile? Yes ___ No ___
2) Look younger? Yes ___ No ___
3) Keep your teeth for life? Yes ___ No ___

905 E. Washington Avenue ● Greenville, SC 29601 ● (864) 232-0440 ● Fax (864) 232-0441

Medical History

Patient Name: _____

	Y or N	
Are you under a physician's care now?	_____	if yes, please explain: _____
Have you ever been hospitalized/had a major operation?	_____	if yes, please explain: _____
Have you ever had a serious head or neck injury?	_____	if yes, please explain: _____
Are you taking any medications, pills, or drugs?	_____	if yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux?	_____	
Have you ever taken Fosamax, Boniva, Actonel or any Other medications containing bisphosphonates?	_____	
Are you on a special diet?	_____	
Do you use tobacco?	_____	
Do you use controlled substances?	_____	
Women: Are you: Pregnant/Trying to get pregnant?	_____	
Taking oral contraceptives?	_____	
Nursing?	_____	

Are you allergic to any of the following? (Please circle)

Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal
Latex Sulfa drugs other
If other, please explain: _____

Do you have, or have you had, any of the following? (Please circle if YES)

AIDS/HIV Positive	Cortisone Medicine	Hemophilia	Radiation Treatments
Alzheimer's Disease	Diabetes	Hepatitis A	Recent Weight Loss
Anaphylaxis	Drug Addiction	Hepatitis B or C	Renal Dialysis
Anemia	Easily Winded	Herpes	Rheumatic Fever
Angina	Emphysema	High Blood Pressure	Rheumatism
Arthritis/Gout	Epilepsy/Seizures	High Cholesterol	Scarlet Fever
Artificial Heart Valve	Excessive Bleeding	Hives/Rash	Shingles
Artificial Joint	Excessive Thirst	Hypoglycemia	Sickle Cell Disease
Asthma	Fainting Spells/Dizziness	Irregular Heartbeat	Sinus Trouble
Blood Disease	Frequent Cough	Kidney Problems	Spina Bifida
Blood Transfusion	Frequent Diarrhea	Leukemia	Stomach/Intestinal Disease
Breathing Problem	Frequent Headaches	Liver Disease	Stroke
Bruise Easily	Genital Herpes	Low Blood Pressure	Swelling of Limbs
Cancer	Glaucoma	Lung Disease	Thyroid Disease
Chemotherapy	Hay Fever	Mitral Valve Prolapse	Tonsillitis
Chest Pains	Heart Attack/Failure	Osteoporosis	Tuberculoses
Cold Sores/Fever Blisters	Heart Murmur	Pain in Jaw Joints	Tumors/Growths
Congenital Heart Disorder	Heart Pacemaker	Parathyroid Disease	Ulcers
Convulsions	Heart Trouble/Disease	Psychiatric Care	Venereal Disease
			Yellow Jaundice

Have you ever had any serious illness not listed above? If yes, please explain: _____

_____

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient: _____ **Date:** _____

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Financial Policy

Thank you for choosing Waterstone Dentistry as your dental care provider. We are committed to the success and care of your dental treatment. The following is a statement of our financial policy, which must be read and signed prior to treatment in our office.

We accept the following forms of payment:

- Cash
- Personal checks (A $40 service charge will be assessed for all returned checks)
- Major Credit Cards: VISA, MasterCard, American Express and Discover
- CareCredit (you can apply online at CareCredit.com and receive 6 months interest free)

Payment in full is due at the time of service unless other arrangements have been made in advance. If you have qualifying insurance, you will be expected to make an estimated payment for that portion not covered by your insurance plan.

- Insurance payments are accepted. Estimates of the insurance payment can be given at the time of each visit. If insurance does not pay the expected amount, a statement will be mailed to you for the remaining balance. You may receive only one statement. Patients are responsible for the difference between the actual insurance payment and the treatment fee.

- Past due balances over 90 days will begin receiving a 23% monthly finance charge or will be forwarded to a collection agency at our discretion. The collection agency will charge an additional 40% to the outstanding account balance as a fee for handling the account.

*Insurance companies have a contract with the patient not the dental professional. Therefore various treatments may be denied or are not a covered expense. All balances are ultimately the responsibility of the patient.

*****ALL APPOINTMENTS THAT ARE 2 HOURS OR MORE REQUIRE A NON-REFUNDABLE DEPOSIT TO RESERVE THE TIME AND A 72-HOUR NOTICE TO CHANGE THE APPOINTMENT*****

Patient Signature: _____ Date: _____

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AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient name _____

Patient number _____

Patient address _____

Patient phone number _____

I authorize the professional office of my dentist named above to release health information identifying me [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services] under the following terms and conditions:

1. Detailed description of the information to be released:

2. To whom may the information be released [name(s) or class(es) of recipients]:

3. The purpose(s) for the release (if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose, if desired by the individual):

4. Expiration date or event relating to the individual or purpose for the release:

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

[For marketing authorizations, include, as applicable: We will receive direct or indirect remuneration from a third party for disclosing your identifiable health information in accordance with this authorization.]

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Dated_____ Patient signature_____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient _____Print Name_____

Source of Authority_____