PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

IF THIS APPOINTMENT IS FOR YOU START HERE

1			
DATE			
LAST NAME	FIRST	M.I.	
PREFERS TO BE CALLED BY			
ADDRESS			
CITY	STATE	ZIP	
HOME PHONE NO.		FAX	
CELL		EMAIL	
BIRTHDATE	AGE	MALE	FEMALE
MARRIED	SINGLE	DIVORCED	WIDOWED
SOCIAL SECURITY NO.			

IF THIS APPOINTMENT IS FOR YOUR CHILD START HERE

DATE			
LAST NAME	FIRST	M.I.	
ADDRESS			
CITY	STATE	ZIP	
HOME PHONE NO.			
BIRTHDATE	AGE	MALE	FEMALE
SCHOOL			GRADE
SOCIAL SECURITY NO.			

IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO

DENTAL INSURANCE 2	
PRIMARY CARRIER	
INSURANCE COMPANY	
GROUP NO.	
EMPLOYER NAME	
INSURED'S NAME	
DATE OF BIRTH	RELATIONSHIP TO PATIENT
INSURED'S I.D. NO.	
INSURED'S SOCIAL SECURITY NO.	
SECONDARY CARRIER	
INSURANCE COMPANY	
GROUP NO.	
EMPLOYER NAME	
INSURED'S NAME	
DATE OF BIRTH	RELATIONSHIP TO PATIENT
INSURED'S I.D. NO.	
INSURED'S SOCIAL SECURITY NO.	

GETTING TO KNOW YOU 3		
IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE? NAME:		
RELATIONSHIP:		
YOU WERE REFERRED TO US BY		
NAME:		
PERSON TO CONTACT FOR EMERGENCY		
NAME:		
CELL NUMBER		
HOME NUMBER		
ADDRESS		
CITY	STATE	ZIP

ACCOUNT INFORMATION 4		
PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT		
NAME		
RELATIONSHIP TO PATIENT	SOCIAL SECURITY NO.	
ADDRESS		
CITY	STATE	ZIP
PHONE NO.		
YOU		
NAME		
OCCUPATION		
EMPLOYER'S NAME		
ADDRESS	CITY	
PHONE NO.	FAX NO.	
YOUR SPOUSE		
NAME		
OCCUPATION		
EMPLOYER'S NAME		
ADDRESS	CITY	
PHONE NO.	FAX NO.	

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models,photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient)______________________'s dental needs.

2. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-½% late charge (18% APR)may be added to my account. If required, I also understand a check of my credit history may be made.

6. Cell Phone: ☐ I consent to the dental practice using my cell phone number to (choose one or both) ☐ call or ☐ text regarding appointments and to call regarding treatment, insurance,and my account. I understand that I can withdraw my consent at any time.

   My cell phone number (include area code)______________________________

   Patient's Signature______________________________ Date_____________

   Parent/Responsible Party's Signature:_________________________________
   Relationship to Patient____

Patient Name

Patient Account No.

DENTAL HISTORY

Medical Alert

Welcome! Please complete both sides of this dental/medical history form so that we may provide you with the best possible dental care.

All information is completely confidential.

What is the reason for your visit today? ______________________________

____

Date of Last Dental Visit? __________ Last Dental Cleaning __________ Last Full Mouth X-rays __________

What was done at your last dental visit? ______________________________

Previous Dentist's Name ______________________________ Telephone __________

Address ______________________________ State __________ Zip __________

How often do you have dental examinations? ______________________________

How often do you brush your teeth? __________ How often do you floss? __________

Have you ever used or are you currently using topical fluoride? ☐ Yes ☐ No

What other dental aids do you use (Interplak, toothpick, etc.)? ______________________________

Do you have any dental problems now? ☐ Yes ☐ No

If yes, please describe: ______________________________

Are any of your teeth sensitive to:

Hot or cold? ☐ Yes ☐ No

Sweets? ☐ Yes ☐ No

Biting or chewing? ☐ Yes ☐ No

Have you noticed any mouth odors or bad taste? ☐ Yes ☐ No

Do you frequently get cold sores, blisters or any other oral lesions? ☐ Yes ☐ No

Do your gums bleed or hurt? ☐ Yes ☐ No

Have your parents experienced gum disease or tooth loss? ☐ Yes ☐ No

Have you noticed any loose teeth or change in your bite? ☐ Yes ☐ No

Does food tend to become caught in between your teeth? ☐ Yes ☐ No

If yes, where? ______________________________

Do you:

Clench or grind your teeth while awake or asleep? ☐ Yes ☐ No

Bite your lips or cheeks regularly? ☐ Yes ☐ No

Hold foreign objects with your teeth (pencils, pipe, pins, nails, fingernails)? ☐ Yes ☐ No

Mouth breathe while awake or asleep? ☐ Yes ☐ No

Have tired jaws, especially in the morning? ☐ Yes ☐ No

Snore or have any other sleeping disorders? ☐ Yes ☐ No

Smoke/chew tobacco or use other tobacco products? ☐ Yes ☐ No

Have you ever had:

Orthodontic treatment? ☐ Yes ☐ No

Oral surgery? ☐ Yes ☐ No

Periodontal treatment? ☐ Yes ☐ No

Your teeth ground or the bite adjusted? ☐ Yes ☐ No

A bite plate or mouth guard? ☐ Yes ☐ No

A serious injury to the mouth or head? ☐ Yes ☐ No

If yes, please describe, including cause ______________________________

Have you experienced:

Clicking or popping of the jaw? ☐ Yes ☐ No

Pain (joint, ear, side of face)? ☐ Yes ☐ No

Difficulty in opening or closing the mouth? ☐ Yes ☐ No

Difficulty in chewing on either side of the mouth? ☐ Yes ☐ No

Headaches, neck aches or shoulder aches? ☐ Yes ☐ No

Sore muscles (neck, shoulders)? ☐ Yes ☐ No

Are you satisfied with your teeth's appearance? ☐ Yes ☐ No

Would you like to keep all of your teeth all of your life? ☐ Yes ☐ No

Do you feel nervous about having dental treatment? ☐ Yes ☐ No

If so, what is your biggest concern? ______________________________

Have you ever had an upsetting dental experience? ☐ Yes ☐ No

If yes, please describe ______________________________

Have you ever been told to take a pre-medication prior to dental treatment? ☐ Yes ☐ No

Is there anything else about having dental treatment that you would like us to know? ☐ Yes ☐ No

If yes, please describe ______________________________

Patient Name

Patient Account No.

MEDICAL HISTORY

Medical Alert

1. Physician's Name ____________ Phone ( ) ____________
   Have you had any medical care within the past two years? ☐ Yes ☐ No
   Describe ____________
2. Have you taken any medication or drugs during the past two years? ☐ Yes ☐ No
3. Are you currently taking an medication, drugs, pills or herbal remedies, including regular dosages of aspirin? ☐ Yes ☐ No
4. Have you ever taken prescription medications for weight loss (diet pills)? ☐ Yes ☐ No
   If yes, did you take any of the following? (Check if yes) ☐ Fen-Phen ☐ Pondimen ☐ Redux ☐ Other
   If yes to any of the above, did you have a medical exam for heart issues? ☐ Yes ☐ No
5. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other similar drugs? ☐ Yes ☐ No
6. Are you aware of having an allergic (or adverse) reaction to any substance or medication? ☐ Yes ☐ No
   If yes, please specify ____________
7. Have you been a patient in the hospital during the past five years? ☐ Yes ☐ No
8. Indicate which of the following you have had, or have at present. Check "Yes" or "No" to each item.

Condition	Yes	No
Heart (Surgery, Disease, Attack)	☐ Yes	☐ No
Chest Pain	☐ Yes	☐ No
Congenital Heart Disease	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No
High/Low Blood Pressure	☐ Yes	☐ No
Mitral Valve Prolapse	☐ Yes	☐ No
Artificial Heart Valve/ Pacemaker	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No
Arthritis/Rheumatism	☐ Yes	☐ No
Cortisone Medicine	☐ Yes	☐ No
Swollen Ankles	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Diet (Special/Restricted)	☐ Yes	☐ No
Artificial Joints (Hip, Knee, etc.)	☐ Yes	☐ No
Kidney Trouble	☐ Yes	☐ No
Ulcers	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Thyroid Problems	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No
Contact Lenses	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No
Chronic Cough	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Hay Fever/Allergy/Hives	☐ Yes	☐ No
Latex Sensitivity	☐ Yes	☐ No
Sinus Trouble	☐ Yes	☐ No
Radiation Therapy	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No
Tumors	☐ Yes	☐ No
Hepatitus A, B, C	☐ A ☐ B	☐ C
Venereal Disease	☐ Yes	☐ No
AIDS/HIV Positive	☐ Yes	☐ No
Cold Sores/Fever Blisters	☐ Yes	☐ No
Blood Transfusion	☐ Yes	☐ No
Hemophilia	☐ Yes	☐ No
Sickle Cell Disease	☐ Yes	☐ No
Bruise Easily	☐ Yes	☐ No
Liver Disease/Yellow Jaundice	☐ Yes	☐ No
Neurological Disorders	☐ Yes	☐ No
Epilepsy or Seizures	☐ Yes	☐ No
Fainting or Dizzy Spells	☐ Yes	☐ No
Nervous/Anxious	☐ Yes	☐ No
Psychiatric/Psychological Care	☐ Yes	☐ No

9. Have you lost or gained more than 10 pounds in the last year? ☐ Yes ☐ No
10. Do you have or have you had any disease, condition, or problem not listed? ☐ Yes ☐ No
11. Women: Are you pregnant or think you could be pregnant? ☐ Yes ____ Months ☐ No Nursing? ☐ Yes ☐ No
12. Do you use birth control prescriptions? ☐ Yes ☐ No

I understand the above information in necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient / Guardian Signature ____________ Date ____________

History Review

Dentist Signature ____________ Date ____________

Cameron Park Dental Care

Thank you for choosing Cameron Park Dental Care. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the payment for this optimal care as easy and manageable for our patients as we possibly can by offering different payment options.

Payment Options:

You can choose from:

- Cash, Visa, Mastercard, American Express, Discover Card
- Convenient monthly payment options through Care Credit

*Once services have been fully rendered payment will be due in full.

Patients who have Dental insurance coverage that pays the office:

All charges incurred are the responsibility of the patient or their guarantor, NOT the Insurance company's. We must emphasize that as your Dental Care Provider, our relationship is with you, not your insurance company. Our office does not guarantee that your insurance company will assist with payment for dental treatment. If your claim is not paid within 60 days, denied or paid at a lesser amount, you will be responsible for the full payment amount.

We recommend treatment based on our patient's dental needs, not based on insurance coverage. We estimate what the insurance will pay based on information that they have provided to us. What the insurance actually pays will be determined when they process the claim. The estimated patient's portion is due and payable at the start of treatment and if the insurance pays less than estimated, we will bill the remainder to the patient or guarantor.

Please note:

A fee of $50.00 is charged for patients who miss or cancel within with at least a 48-hour notice. If you have any questions please do not hesitate to ask. We are here to help you get the dentistry you need or want.

____

Patient, Parent or Guardian's Signature   Date

____

Patient Name (PLEASE PRINT)   Date

Acknowledgement of receipt of Notice of Privacy Practices

You may refuse to sign this acknowledgment

I ______________________________, have received a copy of Notice of Privacy Practices.

____
Signature

____
Print Name

____
Date

If this acknowledgement was signed by a person representative on behalf of the patient, please complete the following:

____
Person Representative's Name

____
Person Representative's Signature

____
Relationship to patient

For Front Staff use only

We attempted to obtain a written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtain because:

Individual refused to sign
Communication barriers prohibited obtaining the acknowledgement
An emergency situation prevented us from obtaining the acknowledgement
Other (please specify) ________________