# Village Dental Sedation Care
# Patient Registration

*To our New Patients:*

*We are thrilled you have chosen us to provide you with excellent dental care! We understand dentistry can sometimes be expensive, time consuming, and inconvenient. We vow to help in any way we can to make dental care as easy and affordable as possible. Your satisfaction is our #1 goal. If there is ever anything we can do to help you feel more comfortable during your visits, please don't hesitate to let our staff know.*

**Patient Information:**

First Name: _____ Middle Initial: _____ Last Name: _____ Preferred Name:_____

Address: _____ City: _____State: ____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birth Date: _____ Age: _____ Social Security Number: _____ Sex: Male ☐ Female ☐

E-mail Address: _____ How did you hear about our office? _____

Would you like us to contact you via text and/or e-mail to confirm appointments? Yes ☐ No ☐

Emergency Contact: _____ Relationship: _____ Phone Number: _____

Please list any individuals with whom we may discuss your treatment and account information:

_____ _____

**Dental Insurance Information:**

Subscriber for This Policy's First Name: _____ Middle Initial: _____ Last Name: _____

Subscriber's Relationship to Patient: _____ Subscriber's Birth Date: _____

Subscriber's Social Security Number: _____ Insurance Company: _____

Subscriber's Employer: _____ Group Number: _____

Subscriber ID: _____ Insurance Phone Number: _____

**Responsible Party (If Someone Other Than Patient):**

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____ City: _____ State/ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birth Date: _____ Age: _____ Social Security Number: _____

**Although dental staff primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have or medications you could be taking could have an important interrelationship with the dental care you will receive. Please answer the following as thoroughly as possible. Thank you!**

1. Are you under a physician's care now? ☐ Yes ☐ No If yes, please explain _____
2. Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes, please explain _____
3. Have you ever had a serious neck or head injury? ☐ Yes ☐ No If yes, please explain _____
4. Do you or have you ever taken Fosamax, Boniva, Actonel or any medications containing bisphosphonates? ☐ Yes ☐ No
If yes, please explain _____
5. Do you use tobacco? ☐ Yes ☐ No If yes, please explain _____
6. Do you use controlled substances? ☐ Yes ☐ No If yes, please explain _____
Female Patients: Are you pregnant/ trying to get pregnant? ☐ Yes ☐ No If yes, when is your due date? _____
Are you taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No
7. Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex
☐ Sulfa Drugs ☐ Insect Bites ☐ Other Please Explain Reaction: _____
_____
8. Do you have or have you ever been prescribed an Epi-pen? ☐ Yes ☐ No If yes, please explain _____
9. What medications, pills, or drugs (prescription or recreational) are you currently taking? _____
_____

Please circle any of the following you have or have had:

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

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes, please explain _____
_____

Comments: _____
_____
_____
_____
_____

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

Signature of Patient/Parent or Guardian _____ Date _____

# IMPORTANT INFORMATION

VILLAGE DENTAL
SEDATION CARE

## Financial and Insurance Information

We will collect estimated co-payments and deductibles on the day services are rendered. A finance charge may be added to your account after 90 days of no account payment activity, or your account could be turned over to an outside collection agency. Patients are expected to pay in full by cash, cashier's check, or major credit card the day services are rendered, unless financial arrangements have been made prior to treatment beginning For your convenience, we do offer information on financing your dental visits from 2 months to 5 years. Please feel free to ask someone about this service.

We perform a complimentary insurance benefits check for those patients who have dental insurance coverage to assist you in better understanding your coverage. It is ultimately your responsibility to be aware of your own dental coverage and provide us with as much information as possible in order to better assist you. We will estimate as closely as possible, what portion your insurance will cover, but be aware that all plans differ in coverage.

- Your dental benefits are based upon a contract made between your employer and your insurance company. If you have any questions regarding your dental benefits, please contact your employer or your insurance company directly.
- Dental benefits differ greatly from medical benefits. Dental benefit plans will never pay for completion of your dental care. It is only meant to assist you.
- Many people receive notification from their insurance company that dental fees are "above usual and customary." An insurance company determines their reimbursement level by surveying a geographical area, calculating the average fee, then determines that 80% of the average fee is customary. Included in the survey are discount dental clinics and managed care facilities, which have several reduced dental fees that bring down the average. Any doctor in private practice will have fees that insurance companies define as "higher than usual and customary."
- Many dental benefit plans tell their participants that they will be covered "up to 50%, 80% or 100%," but do not clearly specify the plan fee schedule allowance, annual maximums, or limitations. It is more realistic to expect dental benefits to cover between 25%-60% of dental services.
- Often, Insurance Companies do not recognize many routine dental services such as composite (tooth colored) fillings, porcelain (tooth colored) crowns and occlusal guards.
- Many plans try to confuse participants by giving the in-network as opposed to the out-of-network benefits. Before deciding on going to an in-network provider of your insurance, you need to evaluate the level of treatment and patient care you will be receiving. Our office is in-network with Delta Dental PPO Premier.

## Appointments, Deposits and Cancellation Information

- We make every effort to provide your dental service(s) in a timely manner. We understand that your time is valuable and want your visit to be as convenient as possible. In order to give you the most effective care, we work within an appointment system and your appointment times are reserved exclusively for you. We make every effort to honor all time commitments and expect that patients extend the same courtesy to us. We aim to give you the time and attention you need when in our office. Please help us achieve this goal by being punctual for your appointment. If you are more than 15 minutes late for your appointment we may need to reschedule you to allow enough time for your treatment.
- For most appointments scheduled, a scheduling deposit will be required. This deposit will go towards your out of pocket cost on the day of treatment.
- I understand that if I am unable to keep my scheduled appointment for any reason I will notify the office at least 48 business hours in advance. For appointments requiring deposits cancelledwith less than 48 business hours notice of the scheduled appointment time, the deposit will be lost. For appointments that do not require a scheduling deposit, I am aware that I will be charged a fee of $50 if I do not provide 48 hours notice of cancellation or do not show up for the appointment.
- If you fail to show-up for 2 appointments, we may not be able to schedule you for any more appointments and you will be scheduled as a work-in patient.

If you understand and agree to the above guidelines for our office, please sign below.

Patient/Guardian Signature: _____ Date: _____

# HIPAA/PRIVACY PRACTICES

VILLAGE DENTAL
SEDATION CARE

I understand that my healthcare information concerning my diagnosis, treatment, payment, and insurance will be disclosed when necessary for filing my insurance and in communication with other health care professionals in the course of treatment of their offices. Limited information will also be disclosed to businesses supporting operations of this office such as dental or medical labs, hospitals, accountants, billing personnel, customer support, answering service, and consultants.

Their businesses are restricted in uses and disclosure of your information by contract. Disclosure may also occur for any necessary legal purposes or appropriate governmental authorities. If a family member or person is paying for your healthcare with your knowledge, we may disclose to that family member or person.

I understand that my files are stored on a computer database. Only staff and janitorial personnel may have access to this office during non-business hours. I understand that this office will make every effort to keep my information secure and correct any violation of my privacy if this should occur.

I understand that I have the right to access, copy, or inspect my healthcare information; the right to restrict disclosures, and obtain an accounting of disclosures. I have the right to voice my concerns about privacy to the practice and/or The Secretary of Health and Human Services within 180 days of my discovery of a disclosure violation without fear of retaliatory acts by the office. I may correct my records in the form of a letter signed by me. I also have the right to revoke my authorization for disclosure. A minimal fee of $.25 per page will be charged to me for copies of records that I request.

I understand that I will receive communication in the form of phone calls, e-mails, text messages, and/or post cards to remind me of an existing appointment, or that it is time to schedule an appointment. I may receive mail containing financial information. Communication may also be sent to me in the form of fax, e-mail, or other electronic means. I understand that if a message is left for me to return a call, the message will contain the doctor's name and phone number. Complete messages concerning my health information may be left on my personal home or work voicemail.

**I have read and understand this office policy. I understand that by signing this agreement, I give permission for the use and disclosure of my personal and health information in order to carry out treatment, payment, insurance claims, and healthcare operations. This office retains the right to revise this privacy policy.**

**Patient/Guardian Signature: _____Date: _____**

**I have read this form and do not wish to sign (Initial) _____**

VILLAGE DENTAL
SEDATION CARE

# SMILE EVALUATION

**How long has it been since you were last at the dentist?** ☐ 6 months ☐ 1-2 years ☐ 3-5 years ☐ 5+ years

**What is your main concern today?**

☐ Tooth Pain ☐ Sensitivity ☐ Broken/Cracked Teeth ☐ Cavities/Decay ☐ Cosmetic Dentistry
☐ Cleaning ☐ Missing Teeth/Implants ☐ Old Dentistry ☐ Gum Disease ☐ Orthodontics ☐ Dentures
☐ Whitening ☐ Sedation Dentistry ☐ Gum Recession ☐ Other, please list: _____

**If our doctors find an issue that should be addressed immediately, are you interested in having treatment done today?** ☐ yes ☐ no

**Do you have any anxiety, fear or bad experiences associated with the dentist office?** ☐ yes ☐ no. If yes would you say that you have ☐ Low Anxiety ☐ Moderate Anxiety ☐ High Anxiety

**Have you ever had sedation dentistry?** ☐ yes ☐ no

**Is there anything you would like to change about your smile?**

_____

**What is most important to you when seeking dental treatment?**

☐ Quality of Service ☐ Technology ☐ Comfort ☐ Fear/Sedation ☐ Cost ☐ Convenient Office Hours
☐ Friendliness of Staff ☐ Cleanliness of Office ☐ Other, please list: _____

**Are you aware of clenching/grinding your teeth?** ☐ yes ☐ no

**Have you ever had periodontal gum treatment (deep cleaning or gum grafting)?** ☐ yes ☐ no

**Have you ever had orthodontic treatment (braces)?** ☐ yes ☐ no

**Are you concerned about bad breath?** ☐ yes ☐ no

**Is there anything else you would like for us to know about you?** _____

_____