

Patient Registration Form

American Dental Association
www.ada.org

Email:			Today's Date:		
Preferred Name: <input type="checkbox"/> Miss <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Dr.			Referred by:		
Name: Last First Middle		Home Phone: include area code ()		Cell Phone: include area code ()	
Address: Mailing address		City:		State: Zip:	
SS#:		Date of Birth:		Sex: M F	
Employer:		Business Phone: include area code ()			
Emergency Contact:		Relationship:		Home Phone: include area code () Cell Phone: include area code ()	
College Student Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time Please provide school info:			School Name:		
Employment Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired			Address:		
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed			Address 2:		
Pref. Pharmacy:		Phone: ()		City, State, Zip:	

Dental Insurance Information

Primary Insurance Information	
Name of Insured:	Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
Insured Soc. Sec.:	Insured Birth Date:
Employer:	Ins. Company:
Address:	Address:
Address 2:	Address 2:
City, State, Zip:	City, State, Zip:
ID#:	Gr#:
Secondary Insurance Information	
Name of Insured:	Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
Insured Soc. Sec.:	Insured Birth Date:
Employer:	Ins. Company:
Address:	Address:
Address 2:	Address 2:
City, State, Zip:	City, State, Zip:
ID#:	Gr#:

Dental Information For the following questions, mark (X) your responses to the following questions.

	Yes	No	DK		Yes	No	DK
Do your gums bleed when you brush or floss?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have earaches or neck pains?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to cold, hot, sweets or pressure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any clicking, popping or discomfort in the jaw?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your mouth dry?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you brux or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any periodontal (gum) treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have sores or ulcers in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had orthodontic (braces) treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear dentures or partials?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any problems associated with previous dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you participate in active recreational activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your home water supply fluoridated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a serious injury to your head or mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink bottled or filtered water?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date of your last dental exam:			
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY				What was done at that time?			
Are you currently experiencing dental pain or discomfort?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date of last dental x-rays:			
What is the reason for your dental visit today?							
How do you feel about your smile?							

over

Medical Information Please mark (X) your responses to indicate if you have or have not had any of the following diseases or problems.

(Check DK if you Don't Know the answer to the question) Yes No DK		Yes No DK																																																																									
Are you now under the care of a physician? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Physician Name: _____ Phone: include area code () _____ Address/City/State/Zip: _____		Have you had a serious illness, operation or been hospitalized in the past 5 years? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> If yes, what was the illness or problem? _____																																																																									
Are you in good health? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Has there been any change in your general health within the past year? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> If yes, what condition was treated? _____ Date of last physical exam: _____		Are you taking or have you recently taken any prescription or over the counter medicine(s)? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements: _____ Do you use controlled substances (drugs)? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>																																																																									
Do you wear contact lenses? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Are you taking, or have you taken, any diet drugs such as Pondimin (fenfluramine), Redux (dextrophenfluramine) or fen-phen (fenfluramine-phentermine combination)? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Are you taking or scheduled to begin taking either of the medications alendronate (Fosamax®) or risendronate (Actonel®) for osteoporosis or Paget's disease? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Date Treatment Began: _____		Do you use tobacco (smoking, snuff, chew, bidis)? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> If so, how interested are you in stopping? Circle one: VERY / SOMEWHAT / NOT INTERESTED Do you drink alcoholic beverages? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> If yes, how much alcohol did you drink in the last 24 hours? _____ If yes, how much do you typically drink in a week? _____																																																																									
Joint Replacement. Have you had an orthopedic total joint replacement (hip, knee, elbow, finger)? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Date: _____ If yes, have you had any complications? _____		WOMEN ONLY Are you: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pregnant? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Number of weeks: _____ Taking birth control pills or hormone replacement? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nursing? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>																																																																									
Allergies - Are you allergic to, or have you had a reaction to: Yes No DK To all yes responses, specify type of reaction.																																																																											
Local anesthetics <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Aspirin <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Penicillin or other antibiotics <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Barbituates, sedatives, or sleeping pills <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sulfa drugs <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Codeine or other narcotics <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		Metals <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Latex (rubber) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Iodine <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hay fever / seasonal <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Animals <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Food <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Other <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>																																																																									
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Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Name of physician or dentist making recommendation: _____ Phone: () _____ Do you have any disease, condition, or problem not listed above that you think I should know about? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Please explain: _____																																																																											
NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment. I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form. Signature of Patient/Legal Guardian: _____ Date: _____																																																																											



DR. JARED URE
DR. RICHARD THOMAS
850.682.4516

OFFICE POLICY

Thank you for choosing Ure Family Dentist. Our policies are listed below for your careful review. These policies are intended to make your visit with us as pleasant as possible, and enable our staff to provide the highest quality of care.

Please read all information and acknowledge by signing below.

1. We ask that you present your insurance card at each visit. It is your responsibility to provide us with the correct information to bill your insurance.
2. If you have a change of address or telephone number(s), please notify our office immediately.
3. **YOUR INSURANCE COVERAGE IS A CONTRACT BETWEEN YOU AND THE INSURANCE COMPANY. WHEN WE VERIFY YOUR COVERAGE, ANY AMOUNT QUOTED TO US BY THE INSURANCE CO. IS NOT A GUARANTEE OF PAYMENT.** It is very important that you understand the provisions of your policy.
4. We will collect your deductible, co-payment, or charge for a non-covered service at the time of your visit.
5. If your insurance denies our charges, or does not pay us in a timely manner, or if your account becomes delinquent (60 days) we reserve the right to refer your account to a collection agency to be reported to the credit bureau.
6. **For appointments that require 60 minutes or more of chair time:** Half of your amount due will be collected at the time the appointment is made, to reserve this time for you. This amount will be applied to your treatment fee at the time of your appointment.
7. **No show or missed appointments:** We understand there may be times when you are unable to keep an appointment. Please inform us at least 24 hours in advance if you have to break your appointment. If an appointment is broken without the courtesy of 24 hours, you will be charged a \$50.00 fee. If three appointments are missed, you will be dismissed from the practice for non-compliance.
8. **Unconfirmed appointments:** If you have not confirmed your appointment either by phone or text, we reserve the right to cancel your appointment.
9. Any balances on your account need to be paid in full before you will be seen again unless a payment arrangement has been made with billing personnel.
10. Returned checks will be subject to a Non-Sufficient Fund Fee of \$35.00.
11. For the safety and privacy of our patients, **only the patient** will be allowed back in the operatories.

Please remember, whether you have insurance or not, you are ultimately financially responsible for payment of your charges. If you have any questions regarding our financial policy, please contact our office.

Thank you very much for reading and adhering to our policies.

I have read and have a full understanding of the financial policy of Ure Family Dentist

Signature: _____ Date: _____



DR. JARED URE
DR. RICHARD THOMAS
850.682.4516

HIPAA COMPLIANCE

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) this practice may use your personal health information for the purposes of treatment, payment, or healthcare operations only. The specific uses and disclosures that we intend to make are described in our Privacy Policy. You have the right to review our Privacy Policy prior to signing this consent form. You may request restrictions on the uses and disclosures described in the privacy policy by describing the requested restrictions in the "Restriction Request" section of this form.

CONSENT SECTION

I, _____, hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment, and healthcare operations. My signature below indicates that I have been given the opportunity to review the Privacy Policy of Ure Family Dentist. Please allow the following person(s) to obtain my healthcare information. (If none, please write NONE)

RESTRICTION REQUEST SECTION

I hereby request the following restrictions on the use and disclosure of my health information.
(Please describe in detail)

Patient Signature

Date



DR. JARED URE
DR. RICHARD THOMAS
850.682.4516

CONSENT FORM

The undersigned authorizes Ure Family Dentist to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Ure to make a thorough diagnosis of the patient's dental needs. I also authorize Dr. Ure to perform any and all forms of treatment, medication and therapy that may be indicated in connection with (name of patient)_____and further authorize and consent that Dr. Ure choose and employ such assistance as he deems fit.

I authorize Ure Family Dentist the right and permission to use and/or publish photographs of me on social media, such as Facebook.

_____YES, YOU MAY USE MY PHOTOS

_____NO, YOU MAY NOT USE MY PHOTOS

SIGNATURE_____DATE_____

PARENT/RESPONSIBLE PARTY _____

RELATIONSHIP TO PATIENT _____