Luxe Family Dental

Patient Registration

Patient Information

Patient's Name: _____

M F Birthdate: _____ SS#: _____

Married Single Divorced Widow E-mail: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home #(_____)_____ Cell #(_____)_____ Work #(_____)_____

Who can we thank for your referral?: _____

IN CASE OF AN EMERGENCY, WHO SHOULD WE CONTACT?

Name:_____ Relation: _____

Home #: (_____) _____ Other #: (_____) _____

Responsible Party **(For Minors Only)**

Name: _____ Relation: _____

M F Birthdate: _____ SS#: _____

Home #(_____)_____ Cell #(_____)_____ Work #(_____)_____

Employer: _____ Occupation: _____

Insurance Information (if applicable)

Insurance Co. Name: _____ Phone :(_____)_____

Address: _____

ID #: _____ Group #: _____

Policy Owner's Name: _____ Relation: _____

Birthdate: _____ SS#: _____

Is patient covered by an additional insurance? Yes No

*THE X-RAYS OF THE PATIENT'S TEETH ARE PROPERTY OF THIS OFFICE BY LAW. AN ADDITIONAL CHARGE WILL BE REQUIRED FOR ANY COPY YOU MAY NEED.

_____ _____

SIGNATURE OF PATIENT / RESPONSIBLE PARTY DATE

Medical History

Physician's Name: _____ Telephone: _____ Last Visit: _____

Are you under the care of a physician? ☐ Yes ☐ No Please explain:_____
Are you taking any medications or drugs? ☐ Yes ☐ No Please List:_____
Have you been hospitalized in the last 5 years? ☐ Yes ☐ No Please explain: _____

ARE YOU ALLERGIC TO OR HAVE HAD AN ADVERSE REACTION TO: ☐ No Allergies
☐ Penicillin ☐ Erythromycin ☐ Codeine ☐ Sulfa ☐ Advil/Motrin ☐ Iodine ☐ Latex
☐ Tetracycline ☐ Local Anesthetics ☐ Barbiturates ☐ Aspirin ☐ Other: _____

Check if you have or ever had…

☐ Yes ☐ No AIDS/HIV	☐ Yes ☐ No Emphysema	☐ Yes ☐ No Nervousness/Anxiety
☐ Yes ☐ No Anemia	☐ Yes ☐ No Epilepsy	☐ Yes ☐ No Pacemaker
☐ Yes ☐ No Arthritis/Rheumatism	☐ Yes ☐ No Fainting/Dizziness	☐ Yes ☐ No Psychiatric Care
☐ Yes ☐ No Artificial Heart Valves	☐ Yes ☐ No Glaucoma	☐ Yes ☐ No Radiation Treatment
☐ Yes ☐ No Artificial Joints	☐ Yes ☐ No Headaches	☐ Yes ☐ No Respiratory Disease
☐ Yes ☐ No Asthma	☐ Yes ☐ No Heart Murmur	☐ Yes ☐ No Rheumatic Fever
☐ Yes ☐ No Back Problems	☐ Yes ☐ No Heart Problems	☐ Yes ☐ No Shortness of Breath
☐ Yes ☐ No Excessive Bleeding	☐ Yes ☐ No Hepatitis	☐ Yes ☐ No Sinus Trouble
☐ Yes ☐ No Blood Disease	☐ Yes ☐ No Herpes	☐ Yes ☐ No Stroke
☐ Yes ☐ No Cancer	☐ Yes ☐ No High Blood Pressure	☐ Yes ☐ No Swollen Feet/Ankles
☐ Yes ☐ No Chemical Dependency	☐ Yes ☐ No Jaundice	☐ Yes ☐ No Thyroid Problems
☐ Yes ☐ No Chemotherapy	☐ Yes ☐ No Jaw Pain	☐ Yes ☐ No Tonsillitis
☐ Yes ☐ No Circulatory Problems	☐ Yes ☐ No Kidney Disease	☐ Yes ☐ No Tuberculosis
☐ Yes ☐ No Cortisone Treatments	☐ Yes ☐ No Liver Disease	☐ Yes ☐ No Tumor on Head/Neck
☐ Yes ☐ No Diabetes	☐ Yes ☐ No Low Blood Pressure	☐ Yes ☐ No Ulcer
☐ Yes ☐ No Depression	☐ Yes ☐ No Mitral Valve Prolapses	☐ Yes ☐ No Venereal Disease

Please list any other disease/condition you may have: _____

Women: Are you pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No
I am aware that when on antibiotics therapy, my birth control may not be effective. _____ Initials

Dental History

Purpose of Today's Visit: _____ Former Dentist: _____
Last Visit: _____ How often do you: Brush?: _____ Floss?: _____
Have you ever had: ☐ Orthodontics ☐ Gum Treatment ☐ Root Canal ☐ Implants ☐ Crowns
Are you happy with the appearance of you teeth? ☐ Yes ☐ No

Check if you have or ever had…

☐ Yes ☐ No Bad Breath	☐ Yes ☐ No Fingernail biting	☐ Yes ☐ No Pain around ear
☐ Yes ☐ No Bleeding gums	☐ Yes ☐ No Grinding teeth	☐ Yes ☐ No Sensitivity to cold
☐ Yes ☐ No Blisters on lips/mouth	☐ Yes ☐ No Gums swollen	☐ Yes ☐ No Sensitivity to hot
☐ Yes ☐ No Broken fillings	☐ Yes ☐ No Jaw pain/tiredness	☐ Yes ☐ No Sensitivity to sweets
☐ Yes ☐ No Burning	☐ Yes ☐ No Lip/cheek biting	☐ Yes ☐ No Smoking
☐ Yes ☐ No Clicking jaw	☐ Yes ☐ No Loose teeth	
☐ Yes ☐ No Dry mouth	☐ Yes ☐ No Mouth breathing	

I CERTIFY THAT ALL THE INFORMATION STATED ON THIS FORM IS CORRECT. I ALSO UNDERSTAND THAT THE DENTIST IS NOT RESPONSIBLE FOR ANY ACTION TAKEN OR NOT TAKEN DUE TO ERRORS WHEN FILLING OUT THIS FORM.

_____	_____	_____
Signature of Patient/Responsible Party	Signature of Doctor	Date

OUR OFFICE POLICIES

X-RAYS AND EXAMINATION

I authorize *The Doctors at Luxe Dental* to perform dental examination, take all x-rays, and all photographs required to properly diagnose my dental health and provide an effective treatment plan. _____ Initials

I authorize Luxe Dental to share my x-rays, pictures, and/or models with others for teaching and/or marketing purposes. All identifying information will be removed. _____ Initials

APPOINTMENTS

Please be aware that we reserve the right to charge *$25.00* to your account for appointments cancelled or broken without a minimum notice of 48 business hours. _____ Initials

INSURANCE

As a courtesy to our patients, we are providers for some dental insurance companies. Most policies do not cover 100% of the cost of your treatment. We will estimate your coverage as closely as possible, based on information we receive from your insurance company, but until we actually receive payment from them, it is just an estimate. I acknowledge responsibility for payment of services rendered on my behalf. I also authorize the office of *Luxe Dental* to file all claims pertaining to my treatment. I authorize my signature to be on file for all insurance claims. **If my insurance plan does not cover completely the cost of my care within 45 days, I acknowledge full responsibility for payments pertaining to my treatment.** _____ Initials

PAYMENTS

Payment is due at the time services are rendered. **Patients are expected to pay in cash, VISA, MASTERCARD or AMEX. SORRY, WE DO NOT ACCEPT PERSONAL CHECKS.** We also accept Carecredit and Wells Fargo Financing which offers various payment plans. This plan only takes a few minutes to apply and allow you to start treatment today and spread payment over time.

Should it be necessary to collect my account through an attorney or collections agency, I hereby agree to pay all costs of collections, all attorney fees, court costs, and any other costs related to the collection of my account.

I HAVE READ THE FINANCIAL POLICY. I UNDERSTAND AND AGREE TO THIS FINANCIAL POLICY.

_____

Patient's Name

_____ _____

Patient's Signature Date

Luxe Family Dental

Notice of Privacy Practice

As required by the privacy regulations created as a result of the health insurance portability and accountability act (HIPAA):

Our office is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We are also required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our office concerning you IIHI. By the federal and state law, we must follow the items of notice of the privacy practices that we have in effect at the time. If you have any questions, regarding this notice of your health information privacy policies, please contact our private officer.

BY SIGNING THIS DOCUMENT, I UNDERSTAND AND AGREE WITH THIS NOTICE.

_____

Patient's Name

_____ _____

Signature of Patient/Responsible Party Date