Congressional Dental Care

Welcome

We are pleased to welcome you/your family to our practice!

Patient Registration Form

To help us meet your dental needs, please fill out this form completely in ink. If you have questions please as someone at the front desk.

Patient Information

Name:____
Last First MI

Preferred Name: ________________ Title:____________ ☐ Male ☐ Female ☐ Single ☐ Married ☐ Other

Birth date ________________ SSN ____________________ Driver's Lic. ______________________________State________

Address ____
City State ZIP

Email____

Home Phone ________________________Mobile ________________________Work ____________________________

Emergency Contact ______________________________________Emergency Number______________________________

How did you hear about us? ____

Minor patients should be accompanied by a parent or guardian at all times.

Dental Insurance Information

PRIMARY

Name of Insured __________________________________

Insured's SSN_______________Insured's DOB__________

Insurance Company ______________________________

Employer_________________ Group________________

Insured's Relationship to Patient______________________

School (full-time student)___________________________

SECONDARY (If any)

Name of Insured __________________________________

Insured's SSN_______________ Insured's DOB _________

Insurance Company ______________________________

Employer_________________ Group________________

Insured's Relationship to Patient______________________

School (full-time student)___________________________

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above insurance company and assign directly to this office all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize this office to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

X____
Responsible Party Signature

X___________________________ ______________
Relationship to Patient Date

X____
Responsible Party Signature

X___________________________ ______________
Relationship to Patient Date

X____ ______________
Responsible Party Signature Date

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Dental Health History

Reason for today's visit____________________

____

Are you currently in pain? ☐ Yes ☐ No
If so, please explain

____

Do you have any dental problems now?
☐Yes ☐ No
If so, please explain

____

Have you ever had complications with previous dental treatment? ☐ Yes ☐ No
If so, please explain

____

Former Dentist____________________________
Date of last dental exam__________________
Date of last dental x-rays_________________
Date of last cleaning ____________________
How often do you brush? _________________
How often do you floss?__________________

Circle "Yes" or "No" to indicate whether you have had any of the following conditions:

Sensitivity to hot or cold Yes No
Sensitivity to sweet Yes No

Avoid one side of the mouth when chewing Yes No
Sensitivity when biting Yes No

Broken / cracked fillings Yes No
Food collection between teeth Yes No

Tobacco use Yes No

Gums swollen or tender Yes No
Gums bleed frequently Yes No

Blisters on lips or mouth Yes No
Sores or growths inside cheek / in the mouth Yes No

Bad breath Yes No
Burning sensation on tongue Yes No
Dry mouth Yes No

Accident involving jaw Yes No

Clicking or popping Yes No
jaw Yes No
Frequent headaches Yes No
Grinding teeth Yes No
Jaw pain or tiredness Yes No
Pain around ear

Yes No
Orthodontic treatment Yes No
Periodontal treatment

Medical Health History

Physician______________________ Phone _______________

Please list all current medications (include prescription, over-the-counter, herbal supplements) and reason for use:

____

____

____

Are you allergic to any of the following?

☐ Aspirin ☐ Codeine ☐ Latex ☐ Penicillin ☐ Valium

Other: ____

Have you ever had any of the following conditions?

☐ Artificial joint/valve ☐ Heart murmur ☐ Mitral valve prolapse ☐ Rheumatic fever

Other: ____

Women Only:

Do you use birth control medication? Yes No
Are you nursing? Yes No
Are you pregnant? (Due date:____________) Yes No

Circle "Yes" or "No" to indicate whether you have had any of the following conditions:

Condition		
AIDS / HIV	Yes	No
Anemia	Yes	No
Arthritis	Yes	No
Asthma or Respiratory problems	Yes	No
Back problems	Yes	No
Blood transfusion (Date:______________)	Yes	No
Cancer	Yes	No
Cardiac pacemaker	Yes	No
Convulsions / Epilepsy / Seizures	Yes	No
Diabetes	Yes	No
Excessive bleeding with extractions / surgery	Yes	No
Heart problems	Yes	No
Hepatitis or Liver problems	Yes	No
High or Low blood pressure	Yes	No
Kidney problems	Yes	No
Nervousness or Anxiety	Yes	No
Neurological Disorder	Yes	No
Psychological Care	Yes	No
Radiation or Chemotherapy treatment	Yes	No
Sexually transmitted disease/infection	Yes	No
Stroke	Yes	No
Thyroid disorder	Yes	No
Tuberculosis	Yes	No
Other: ______________________	Yes	No

I, the undersigned, certify that the above questions have been accurately answered to the best of my knowledge. I understand that providing incorrect information about my medical or dental history can be dangerous to my health.

X____ ______________
Responsible Party Signature Date

X____ ______________
Attending Dentist Signature Date

Appointment Policy

We respect that your time is valuable therefore we make every effort to see our patients at their scheduled time. As a courtesy to our staff and other patients if your are 15 minutes late for your scheduled appointment we may need to reschedule you for another date and time
We request that patients call our office at least 24 hours prior to their scheduled appointment. Appointments that are cancelled with less than 24 hour notice are considered a broken appointment and may be subject to a cancellation fee, not to exceed $75.
SOME OFFICE VISITS REQUIRE A $10 INFECTION CONTROL FEE, THIS FEE COVERS THE DISPOSABLE ITEMS, STERILIZATION AND DISINFECTANT TECHNOLOGY INVOLVED IN YOUR VISIT AS REQUIRED BY LAW (OSHA).

Financial Policy

We are dedicated to providing the best possible care and service to you and regard the complete understanding of your financial responsibilities as an essential element of your care and treatment. If you have any questions, please discuss them with our office manager.
ALL PATIENTS MUST COMPLETE OUR OFFICE HEALTH HISTORY AND FINANCIAL POLICY IN ITS ENTIRETY PRIOR TO BEING SEEN BY THE DOCTOR.

INSURANCE:

Your insurance policy is a contract between you and your insurance company, the doctor is not involved. As a courtesy, we will bill indemnity insurance plans directly. Any co-payment and/ or co-insurance or deductible is payable AT THE TIME OF SERVICE. The percentage quoted to you is an ESTIMATE and not a guarantee of payment from your insurance company. Please note, the account holder is responsible for all treatment payments that their respective insurance company denies and does not pay within 90 days. If an overpayment occurs, we will refund the payment within 30 days (please allow time for processing).
If your account has not been paid between 90 days the balance will be due in full by the responsible party regardless of insurance claim status

FINANCE CHARGES:

Accounts past due more than 90 days will be subject to a 2% interest charge per month. In the event that the account is turned over to a collection agency, the patient or responsible party shall be liable for any clerical, legal and collection fees incurred, up to 40% of the outstanding balance. Also, please note, balances sent to our collection agency will be billed to our usual customary fees, which forfeit your insurance benefits.
Please note: A fee of $35 is applied to all returned checks

PAYMENT OPTIONS:

- Visa, MasterCard, Discover, American Express, Cash, or Check (by pre-approval only). We offer a 8% courtesy accounting adjustment to patients who pay their total treatment cost in full with cash and 5% for patients who pay with a credit card prior to care.
- No INTEREST[1] and convenient low monthly payment plans from CareCredit

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For person financially responsible for payment
Name: ____
Last First MI
SSN: ____

Preferred method of Payment: ☐ Cash ☐ Credit Card ☐ Check (by pre-approval only)

Visa/MC/Amex/Discover # ______________________________

If patient is a minor, name of legal guardian or parent: ______________________________

Payment is due at time of service
unless other arrangements have been approved, prior to treatment.

I have read and understand the financial and appointment policy and agree to abide by its terms. I also understand this policy may be amended from time to time by the practice.

X____ ______________
Patient, Parent or Guardian Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ____, have received a copy of this office's Notice of Privacy Practice.

____
{Please Print Name}

____
{Signature}

____
{Date}

For Office Use Only

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

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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