PATIENT REGISTRATION FORM

STATEMENT BILLING INFORMATION

ACCOUNT NAME _____

ADDRESS _____

CITY _____

STATE _____ ZIP _____

HOW LONG? _____ ☐ RENT ☐ OWN

HM PH. _____

WK PH. _____ EXT. _____

SS # _____ BIRTH DATE _____

DRIVER'S LICENSE NUMBER _____

EMPLOYER _____ HOW LONG? _____

SPOUSE INFORMATION

NAME _____

HM PH. _____

WK PH. _____ EXT. _____

SS # _____ BIRTH DATE _____

DRIVER'S LICENSE NUMBER _____

EMPLOYER _____ HOW LONG? _____

INSURED

NAME _____ RELATIONSHIP _____

EMPLOYER _____ CONTACT _____

ADDRESS _____

CITY _____

STATE _____ ZIP _____

INSURANCE CO _____

PHONE _____

ADDRESS _____

CITY _____

STATE _____ ZIP _____

PLAN # _____ GROUP # _____

UNION # _____

INSURED

NAME _____ RELATIONSHIP _____

EMPLOYER _____ CONTACT _____

ADDRESS _____

CITY _____

STATE _____ ZIP _____

INSURANCE CO _____

PHONE _____

ADDRESS _____

CITY _____

STATE _____ ZIP _____

PLAN # _____ GROUP # _____

UNION # _____

OTHER INSURANCE

NAME _____ ADDRESS _____

CITY _____ STATE _____ ZIP _____

SS # _____ BIRTH DATE _____ EMPLOYER _____ CONTACT _____

EMPLOYER ADDRESS _____ EMP CITY _____ EMP ST _____ EMP ZIP _____

INSURANCE CO _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PLAN # _____ GROUP # _____ UNION # _____

WHOM MAY WE THANK FOR REFERRING YOU? NAME _____

OTHER NEAREST RELATIVE NOT LIVING WITH YOU

NAME _____ ADDRESS _____

CITY _____ STATE _____ ZIP _____ PH _____

A **FINANCE CHARGE** is imposed on those charges not paid in full within 90 days of the date you were first billed for the charges. The balance on which any **FINANCE CHARGE** is computed is determined by totaling the charges not paid within the time period shown below on the front of your billing statement.

Signature _____ Date _____

Toto Dental Associates Financial Policy and Agreement

Thank you for choosing us for your dental needs. We are committed to providing you with excellent care. Our convenient financial arrangements are based on an open and honest discussion of recommended treatment options, respective fees and patients' financial capabilities. (please initial each after reading)

_____**Payment**

Payment in full is due at the time of service unless prior financial arrangements are made. We offer several payment options:

- Cash, Checks, Visa, MasterCard, Discover and American Express, Care Credit
- Pre-payment and Cash discounts
- Monthly payment plans in accordance with the office credit guidelines
- Specialty services – 25% deposit is due at the time of appointment scheduling for all major procedures

_____**Insurance**

Our office is committed to helping patients maximize their benefits. Because insurance policies vary greatly, we can estimate your coverage in good faith, but cannot guarantee it. As a service to our patients, we will be happy to manage all claim submission and follow up on your behalf. After your treatment services have been submitted, please allow up to 45 days to receive your direct reimbursement from your insurance company. If you have any questions, our courteous staff is always available to answer them.

_____**Minors**

Payment for services for the treatment of minors can be made by check, cash or credit card and is the responsibility of the adult accompanying that minor.

_____**Missed Appointments**

Once an appointment has been made, that time is reserved specifically for you. We reserve the right to charge a fee for all canceled or missed appointments without 24 hours notice.

_____**Service Charges**

The policy of this office is to charge 1.25% interest monthly (12% annual percentage rate) or a billing charge to all accounts over 90 days past due. There will also be a $35.00 fee for returned checks.

_____**Collection Fees**

Fees incurred to collect payment will be billed to and payable by the patient's account holder.

_____**Financial Consent**

The patient (account holder) agrees to be fully responsible for total payment of treatment performed in this office.

I understand and agree to this Financial Policy and Agreement

_____ _____

Signature of Patient /responsible party Date

Name _____ Birthdate _____ Social Security # _____

Physician _____ Office Phone _____ Date Of Last Exam _____

Patient Medical History

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain _____	☐	☐
3. Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking _____	☐	☐
4. Have you ever taken Phen-Fen/Redux?	☐	☐
5. Do you use tobacco?	☐	☐
6. Do you use controlled substances?	☐	☐
7. Are you wearing contact lenses?	☐	☐

9. Are you allergic to or have you had any reaction to the following?	Yes	No
Local Anesthetics (e.g., Novocaine)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g., Nickel, Mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other (please list) _____	☐	☐

Women Only

10. a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are your taking oral contraceptives?	☐	☐

8. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pain	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever/Allergies	☐	☐
Fainting/Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy/Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Diseases	☐	☐	Hepatitis/Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Mitral Valve Prolapse	☐	☐
Thyroid Problems	☐	☐	Stomach Troubles/Ulcers	☐	☐	Other _____	☐	☐

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐

	Yes	No
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials?	☐	☐
If yes, date of placement _____		
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐

I understand that I have answered the above to the best of my knowledge, and the information is accurate and correct.

Signature of patient (or parent if minor) _____ Date _____