Welcome to All Access Dental

Registration

Today's Date _____/_____/_____

Last Name _____ First Name _____

If Patient is under 18, Parent/Legal Guardian Last Name _____ First Name _____

Home phone # _____ Alt phone # (cell or work) _____

Address _____ Apt # _____

City _____ State _____ Zip Code _____

Patient Date of birth : _____/_____/_____ Sex: ☐ Female ☐ Male ☐ Single ☐ Married

Soc. Sec # _____ E Mail: _____@_____

In case of emergency call: Name _____ phone # _____

Relationship to patient: ☐ Parent ☐ Guardian ☐ Friend Other: _____

Insurance Info

Do you have insurance? ☐ Yes ☐ No

Name of Insurance Company _____ phone # _____

Policy # _____ Group # _____ Subscriber Social Security # _____

Subscriber Name _____ Subscriber D.O.B. _____/_____/_____

Claims Address _____

DENTAL HISTORY

Former dentist _____ phone # _____

Address _____City_____State_____Zip_____

Date of last dental visit _____/_____/_____ Date of last dental x-ray _____/_____/_____

How often do you brush? _____ How often do you floss? _____

Physician Name _____phone #_____ Date of last visit _____/_____/_____

Please check every box if you have had any of the following:

	Yes	No		Yes	No		Yes	No
Bad breath	☐	☐	Food collection between teeth	☐	☐	Orthodontic treatment	☐	☐
Bleeding gums	☐	☐	Foreign objects	☐	☐	Pain around ear	☐	☐
Blisters on lips or mouth	☐	☐	Grinding teeth	☐	☐	Periodontal treatment	☐	☐
Burning sensation on tongue	☐	☐	Gums swollen or tender	☐	☐	Sensitivity to cold	☐	☐
Chew on one side of mouth	☐	☐	Jaw pain or tiredness	☐	☐	Sensitivity to heat	☐	☐
Cigarette, pipe, or cigar smoking	☐	☐	Lip or cheek biting	☐	☐	Sensitivity to sweets	☐	☐
Clicking or popping jaw	☐	☐	Loose teeth or broken fillings	☐	☐	Sensitivity when biting	☐	☐
Dry mouth	☐	☐	Mouth breathing	☐	☐	Sores or growths in your mouth	☐	☐
Fingernail biting	☐	☐	Mouth pain, brushing	☐				

HEALTH HISTORY

Patient Name_____ Date_____/_____/_____

Reason for today's visit _____

Have you ever taken any of the group of drugs collectively referred to as 'fen-phen'? These include combinations of the drug Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine) ?

☐ Yes ☐ No

Please check every box if you have had any of the following:

	YES	NO		YES	NO		YES	NO
AIDS/HIV	☐	☐	Epilepsy	☐	☐	Radiation treatment	☐	☐
Anemia	☐	☐	Fainting or dizziness	☐	☐	Respiratory disease	☐	☐
Arthritis, Rheumatism	☐	☐	Glaucoma	☐	☐	Rheumatic fever	☐	☐
Artificial heart valves	☐	☐	Headaches	☐	☐	Scarlet fever	☐	☐
Artificial joints	☐	☐	Heart murmur	☐	☐	Shortness of breath	☐	☐
Asthma	☐	☐	Heart problems	☐	☐	Sinus trouble	☐	☐
Back problems	☐	☐	Hepatitis Type ____	☐	☐	Skin rash	☐	☐
Bleeding abnormally, with extractions or surgery	☐	☐	Herpes	☐	☐	Special diet	☐	☐
Blood disease	☐	☐	High blood pressure	☐	☐	Stroke	☐	☐
Cancer	☐	☐	Jaundice	☐	☐	Swollen feet or ankles	☐	☐
Chemical dependency	☐	☐	Jaw pain	☐	☐	Swollen neck glands	☐	☐
Chemotherapy	☐	☐	Kidney disease	☐	☐	Thyroid problems	☐	☐
Circulatory problems	☐	☐	Liver disease	☐	☐	Tonsillitis	☐	☐
Congenital heart lesions	☐	☐	Low blood pressure	☐	☐	Tuberculosis	☐	☐
Cortisone treatments	☐	☐	Mitral valve prolapse	☐	☐	Tumor or growth on head or neck	☐	☐
Cough, persistent or bloody	☐	☐	Nervous problems	☐	☐	Ulcer	☐	☐
Diabetes	☐	☐	Pacemaker	☐	☐	Venereal disease	☐	☐
Emphysema	☐	☐	Psychiatric care	☐	☐	Weight loss, unexplained	☐	☐

Are you pregnant? ☐ Yes ☐ No Due date _____ Are you nursing? ☐ Yes ☐ No

Are you taking birth control pills? ☐ Yes ☐ No

MEDICATIONS: List any medications you are currently taking and the correlated diagnosis

_____

_____

ALLERGIES: ☐ Aspirin ☐ Barbituates (sleeping pills) ☐ Codeine ☐ Iodine ☐ Latex
☐ Penicillin ☐ Sulfa ☐ Local Anesthetic ☐ Other _____

Patient's Signature _____Date _____/_____/_____
(Parent/Legal Guardian must sign if patient under 18)

Doctor's Signature _____Date _____/_____/_____

CONSENT FOR DENTAL TREATMENT

Patient's Name: _____ Date of birth: _____

1. I hereby authorize the Dentist at All Access Dental and/or other such persons as he/she may appoint to perform any necessary dental; procedures as deemed appropriate as part of the dental treatment.

2. I understand that Dental treatment may include examination, prophylaxis, restorations, endodontics, x-rays, surgery and extractions for the purpose of maintaining, improving and/or restoring soft and hard tissue to a healthy state.

3. I hereby authorize and request dentists at All Access Dental and/or such designees or assistants as may be selected by him, to perform the following procedure as per dentists treatment plan.

4. I understand that the risks involved in the above described treatment or procedure(s) include but are not limited to bleeding, swelling, and sensitivity.

5. I understand that unforeseen conditions or circumstances may arise during the course of treatment: hence, I consent to and authorize the performance of any care, procedure or treatment not specified above that the dentist reasonably believes necessary or available as a result of unforeseen events.

6. Additionally, I consent to the administration of any local anesthetic that the dentist deems necessary. I understand that the risks involved with the administration of local anesthetics include but are not limited to: nerve injury, and stiffness of the jaw (trismus).

7. It has been explained to me the option of not using local anesthetic for my treatment.

8. I confirm that I have had the opportunity to ask any questions regarding the patient's care at the dental office and that all such questions (if any) have been answered fully and satisfactorily.

9. I certify that I have read this document and understand its contents. I acknowledge that dental treatment, associated risks and related dental education materials have been explained to my satisfaction.

10. This consent will remain in effect until I choose to terminate it.

I have read and understand the above:

_____Date:_____
Patient/Representative Signature (Parent/Legal Guardian must sign if patient under 18)
Dentist signature: _____ Date: _____

Telephone consent obtained from: _____
Witness: _____ Witness: _____

PART A

ASSIGNMENT OF FINANCIAL RESPONSIBILITY AND RELEASE OF INFORMATION

1. I authorize the release of any dental benefit information necessary to process my insurance claim(s).
2. I authorize and request payment of dental benefits directly to All Access Dental.
3. I agree that this authorization will cover all or partial dental services rendered.
4. I understand I am financially responsible for any charges whether or not paid by the insurance plan and further agree to pay All Access Dental for any and all patient responsible balances, co-payments, deductibles and non-covered services indicated by my insurance policy.
5. I agree that a photocopy of this form may be used in lieu of the original.

_____ _____ _____

Patient/Representative Signature Print Name Date
(Parent/Legal Guardian must sign if patient under 18)

PART B

PAYMENT IS REQUIRED AT THE TIME OF YOUR VISIT!!

In an effort to provide you with flexible payment arrangements, we have expanded our payment policy to offer the following payment options:

☐ **Payment by Cash** ☐ **Payment by Check** ☐ **Payment by Credit Card**

Please circle your choice, sign below and return to receptionist before treatment. Our office is enrolled in the *Care Credit Program*, as well as additional financial assistance programs. These programs provide financing for dental treatment above $300. Please speak to the Office Manager if you are interested in applying for either of these plans.

If none of the above applies, please see the office manager. Thank you.

_____ _____ _____

Patient/Representative Signature Print Name Date
(Parent/Legal Guardian must sign if patient under 18)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
(Print Patient's Name)

_____
(Signature-Parent/Legal Guardian must sign if patient under 18)

_____
(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
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please specify)

_____

_____

_____

This Form is educational only, does not constitute legal advice and covers only federal and state law (August 14, 2002)