



Pauley Family Dentistry

A FAMILY TRADITION OF CRAFTSMANSHIP AND CARE

Patient Registration

Today's Date _____

Welcome to our dental family! We're excited to care for you and your smile. These forms give us important information about your help and dental history so we can provide safe, effective care for you and your family. We appreciate your trust and look forward to caring for your smile.

Last Name _____ First Name _____ MI _____ Date of Birth _____

Gender ☐ M ☐ F Soc. Sec. # _____ Mark One: ☐ Single ☐ Married ☐ Separated ☐ Widow

Mailing Address _____ City _____ State _____ Zip Code _____

Email _____ Home Phone # (____) _____ Cell Phone # (____) _____

Driver's License # _____

Work Phone # (____) _____ Employer _____

If patient is a minor: Mother's DOB _____ Father's DOB _____

Name of Parent _____ Parent Soc. Sec. # _____

Parent Employer _____ Parent Phone # (____) _____

Person Responsible for Account _____ Relationship _____

Emergency Contact _____ Relationship _____ Phone # (____) _____

If you are filling this form out on behalf of another person, what is your relationship to that person?

Name _____ Relationship _____

How did you hear about us?

☐ In-home Mailer ☐ Social Media ☐ Insurance ☐ Practice Website ☐ Internet ☐ Family/Friend/Coworker

Other _____ Who can we thank for your visit? _____

Dental Insurance Information (Primary Carrier)

Insured's Name _____

Insured's Employer _____

Insured's DOB _____

Insurance Co _____

Insurance Co Address _____

Insurance Phone # (____) _____

Group # _____ Member ID # _____

Dental Insurance Information Secondary Coverage

Insured's Name _____

Insured's Employer _____

Insured's DOB _____

Insurance Co _____

Insurance Co Address _____

Insurance Phone # (____) _____

Group # _____ Member ID # _____

Dental History

Please share the following dates:

Your last cleaning _____ Your last oral cancer screening _____ Your last complete X-rays _____

What would you like to change about your smile?

☐ Color ☐ Bite ☐ Chipped Teeth ☐ Spaces ☐ Crowding ☐ Smile Makeover ☐ Missing Teeth ☐ Whiter Teeth

What is the most important thing to you about your dental visit today? _____

What is the most important thing to you about your future smile and dental health? _____

Is there anything else you would like us to know about your dental health? _____



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PATIENT NAME _____ Birth Date _____

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? Yes No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____

Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____

Are you taking any medications, pills, or drugs? Yes No If yes, please explain: _____

Have you ever taken Fosamax, Boniva, Actonel, Reclast or any other medications containing bisphosphonates? Yes No

Do you use tobacco or vape? Yes No

Do you use controlled substances? Yes No

Women: Are you pregnant/Trying to get pregnant? Yes No **Taking oral contraceptives?** Yes No **Nursing?** Yes No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other If "Other," please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Recent Weight Loss	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Renal Dialysis	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Rheumatic Fever	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Rheumatism	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Scarlet Fever	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	Hives or Rash	Yes	No	Shingles	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hypoglycemia	Yes	No	Sickle Cell Disease	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Irregular Heartbeat	Yes	No	Sinus Trouble	Yes	No
Asthma	Yes	No	Fainting Spells/Dizziness	Yes	No	Kidney Problems	Yes	No	Spina Bifida	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Leukemia	Yes	No	Stomach/Intestinal Dz	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Liver Disease	Yes	No	Stroke	Yes	No
Breathing Problem	Yes	No	Frequent Headaches	Yes	No	Low Blood Pressure	Yes	No	Swelling of Limbs	Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Lung Disease	Yes	No	Thyroid Disease	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Mitral Valve Prolapse	Yes	No	Tonsillitis	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Osteoporosis	Yes	No	Tuberculosis	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Pain in Jaw Joints	Yes	No	Tumors or Growths	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Murmur	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No
Congenital Heart Disorder	Yes	No	Heart Pacemaker	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Radiation Treatments	Yes	No	Yellow Jaundice	Yes	No

Have you ever had any serious illness not listed above? Yes No If "Yes," please explain: _____

Please list any medications or supplements you are currently taking: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____



Financial Policy

Patient Name (print) _____

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment. Payment is due at the time service is provided. Our office accepts cash, personal checks, credit cards and outside patient financing.

Please check if you would like more information about financing options.

Please note: Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance, you will be responsible for any collection and/or legal charges up to 35%.

Do You Have Insurance?

- We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company.
- As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however, it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits will determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.
- We ask that you pay the deductible and co-payment, which is the estimated amount, not covered by your insurance company, by cash, check, credit card or Patient Financing at the time we provide the service to you.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

We thank you for the opportunity to serve your dental health care needs and welcome any question you may have concerning your care or our financial policy.

Consent:

I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge and/or attorney fee will be added to any overdue balance. By signing below, you are authorizing us to call you at any number you provide including calls to mobile/cellular or similar devices for any lawful purpose. You agree to any fees or charges that you may incur for an incoming call from us, and/or outgoing calls to us, to or from any such number, without reimbursement from us.

Patient Signature (Parent if child)

Date



Patient Name (print) _____

Acknowledgement of Receipt of Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

****You may refuse to sign this acknowledgement****

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

Patient Name (printed)

Signature

Date

Authorization to Release Information

Purpose: This form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself.

I, _____, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

Name (Printed)

Relationship

Name (Printed)

Relationship

Name (Printed)

Relationship

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*)