Aesthetic Dental Center

ADULT REGISTRATION FORM

Patient's Name _____ Preferred Name _____

Birthdate _____ Age _____ Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Social Security Number_____

Address_____ City _____ State _____ Zip _____

Home Phone Number _____ Cell Phone Number_____

Email address_____

Employer _____ Position _____ How Long? _____

Employer Address _____ Phone _____

City _____State _____ Zip _____

Spouse's Name _____ SS# _____ Birthdate _____

Phone Number _____ Cellular phone number _____

Spouse's Employer _____ Phone _____

Employer Address _____

City _____State _____ Zip _____

Who should we notify, other than your spouse, in case of emergency?

Name _____ Relationship _____

Address _____ Phone _____

City _____State _____ Zip _____

Previous Dentist_____ Phone _____

How did you hear about our office?

☐ Internet ☐ Insurance

☐ Family Member or Friend: _____

☐ Doctor's Office: Dr._____

☐ Other: (Please specify)_____

(please continue on the back side)

Payment Information: ***All services must be paid before or on the date of service***. Patients with insurance or other coverage must complete all the required information.

Primary Insurance:
Subscriber's Name _____ SS#_____

Relationship of Patient: ☐ Self ☐ Spouse ☐ Child Birthdate _____

Insurance Company _____ Group# _____

Address _____ Phone _____

_____

Secondary Insurance:
Subscriber's Name _____ SS#_____

Relationship of Patient: ☐ Self ☐ Spouse ☐ Child Birthdate _____

Insurance Company _____ Group# _____

Address _____ Phone _____

_____

AUTHORIZATION FOR RELEASE OF INFORMATION: (All patients/guarantors must sign)
I certify that the above information is correct. I authorize release of any information relating to my dental claims. I understand that I am responsible for all costs of dental treatment. I hereby authorize payment of the group insurance benefits otherwise payable to me directly to Aesthetic Dental Center.

Patient Signature _____ Date _____

PERMISSION FOR TREATMENT: (All patients/guarantors must sign)
I hereby give my permission to Aesthetic Dental Center's dentists to provide dental treatment as deemed necessary.

Patient Signature _____ Date _____

PAYMENT AGREEMENT: (All patients/guarantors must sign)
I understand that my Insurance Policy is between the insurance company and myself and I am liable to Aesthetic Dental Center for services rendered. I also understand I will be furnished with an **estimate** regarding my insurance benefits at the onset of treatment.
I agree to pay Aesthetic Dental Center for all dental treatment at the time of service. I promise to pay my account until my balance has been paid in full. Should my account become past due, I will be charged 1.5% per month interest with $25.00 late charge fee on the overdue amount. I also understand that should my account become delinquent, it may be turned over for collection, including any attorney's fees incurred.

Patient Signature _____ Date _____

Please remember that once an appointment has been made, this time is reserved specifically for you. No charge will be made for rescheduling an appointment, provided early notice of *at least* 2 business day is given. Otherwise a minimum charge of $50 per hour may be incurred. We reserve the right to not reschedule your appointment.

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MEDICAL HEALTH QUESTIONAIRE

Patient's Name _____ Date of Birth _____
Family Physician's Name _____
Physician's Address _____
Physician's Phone Number _____

1. Are you under a physician's care at this time? YES NO
   Since when _____ Why? _____
2. Are you taking any medications at this time, including birth control? YES NO
   If yes, please specify: _____
3. Are you allergic to penicillin, codeine, local anesthetics, tranquilizers or any other medications? YES NO
   If yes, please specify: _____
4. *Women:* Are you pregnant or suspect you may be? YES NO
   If yes, when is your due date? _____
5. Do you have, or have you had, any of the following diseases or conditions: (please circle)

Artificial Heart Valve	YES	NO	Hepatitis: Type _____	YES	NO
AIDS/HIV+	YES	NO	High Blood Pressure	YES	NO
Angina	YES	NO	Jaundice	YES	NO
Arthritis	YES	NO	Joint Prosthesis	YES	NO
Asthma	YES	NO	Kidney Disease	YES	NO
Bleeding Problems	YES	NO	Latex Allergy	YES	NO
Blood Disorders	YES	NO	Liver Problems	YES	NO
Cancer	YES	NO	Low Blood Pressure	YES	NO
Chemo/Radiation Therapy	YES	NO	Lung Disease	YES	NO
Cosmetic Surgery	YES	NO	Pacemaker	YES	NO
Diabetes	YES	NO	Psychiatric Care	YES	NO
Drug Addiction	YES	NO	Rheumatic Fever	YES	NO
Emphysema	YES	NO	Smoke/Chew Tobacco	YES	NO
Epilepsy/Seizure Disorders	YES	NO	Stroke	YES	NO
Glaucoma	YES	NO	Thyroid Problems	YES	NO
Heart Attack	YES	NO	TMJ disorder	YES	NO
Heart Surgery	YES	NO	Tuberculosis	YES	NO
Heart Murmur	YES	NO	Ulcer	YES	NO
Heart Problems	YES	NO	**Do you need to be Pre-Medicated?**	YES	NO

6. Do you have any disease condition, or problem not listed?
   If yes, please specify: _____

I certify that the above information is complete and accurate. I will inform my dentist of any change in my health and/ or medication.

Patient's Signature _____ Date _____
(Parent or Guardian if patient is a minor)

Doctor's Signature _____ Date _____