# Eric S. Powell D.D.S

## DENTAL REGISTRATION

Date__________________

Patients Name__________________ Preferred Name__________________

Date of Birth__________________ Gender : M F Single Married

Mailing Address__________________City__________________State__________Zip__________

Home Phone Number__________________Work Phone Number__________________SS#__________________

E-mail__________________(for appointment confirmation and notifications)

Would you like to receive text confirmations? Yes No Phone Number__________________

Occupation__________________Employer__________________

If Student, name of School/College__________________ Part-time Full-time City__________State__________

Whom may we thank for referring you to our office?__________________

**If person responsible for patient's account is different from patient or if patient is a minor, please indicate below:**

Name of Responsible Party__________________Relationship to Patient__________________

### PRIMARY INSURANCE INFORMATION

Policy Holders Name__________________Relationship to Patient__________________

ID/SS#__________________Date of Birth__________________Employer__________________

Insurance Co.__________________Phone Number__________________Group#__________________

Insurance Address__________________City__________________State__________Zip__________

### SECONDARY INSURANCE INFORMATION

Policy Holders Name__________________Relationship to Patient__________________

ID/SS#__________________Date of Birth__________________Employer__________________

Insurance Co.__________________Phone Number__________________Group#__________________

Insurance Address__________________City__________________State__________Zip__________

### Answers to the following questions are for our records only and will be considered confidential

1. Have you or any member of your family been seen by us before? Yes No
   If yes, which family member (s)?__________________
2. Date of last physical examination__________________Physician's Name__________________
3. Date of last dental examination__________________Date of last dental x-rays__________________
4. Previous Dentist's name__________________City/State__________Phone Number__________________
5. Are you having pain or discomfort at this time? Yes No
6. Do you feel nervous about having dental treatment? Yes No
7. Have you ever had a bad experience in a dental office? Yes No
8. Have you ever experienced difficulty getting numb for dental treatment? Yes No
9. Is there anything you dislike about your smile? Yes No
10. Have you ever needed to see a Periodontist? Yes No
11. Have you been under the care of a medical doctor during the past two years? Yes No
12. Have you ever had any excessive bleeding requiring special treatment? Yes No

PLEASE COMPLETE BOTH SIDES

## AUTHORIZATION FOR RELEASE OF INFORMATION TO FAMILY MEMBERS

I authorize Powell Family Dentistry to allow the release my dental and billing information to the following individual(s):

1. ________________________________________ Relationship to Patient: ______________________

2. ________________________________________ Relationship to Patient: ______________________

## EMERGENCY CONTACT

Please provide emergency contact

Name: ______________________________________________ Phone number: (_________)____________________________

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for the action they take or do not take because of errors or omissions that I have made in the completion of this form and that all questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

## FINANCIAL POLICY

Dear Patient:

Thank you for choosing us as your healthcare provider. The following is our Financial Policy. Our main concern is that you receive proper and optimal treatment needed to restore your dental health. Therefore, if you have any questions or concerns about our payment policies, please do not hesitate to contact our office staff. We ask that all patients read and sign our Financial Policy as well as complete our Patient Information form prior to seeing the doctor.

Payment for services is due at the time services are rendered. We accept cash, checks, Visa, MasterCard and Discover. For your convenience, we do offer financing through Care Credit. We will be happy to help you process your application and your insurance claim for your reimbursement as long as you bring the required information.

Our Financial Policy is as follows:

1. Payment for services is due in full at the time of treatment including any co-payments that are estimated.
2. Your insurance policy is a contract between you, your employer and the insurance company. We are not a party to that contract. Our relationship is with you, not your insurance company.
3. All charges are your responsibility whether your insurance company pays or not. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
4. Fees for these services, along with unpaid deductibles and co-payment are due at the time of treatment.
5. If the insurance company does not pay after 60 days, we require you to pay the balance due with cash, check, or credit card.
6. Returned checks will be subject to additional fees.
7. All balances over 90 days will be reviewed and turned over to an agency for payment or will be sent to our Legal Counsel. You will be responsible for any additional charges incurred.
8. **We reserve the right to charge a fee of $50 per hour for failed appointments or broken appointment when less than 24 hour notice is received.**

We understand that temporary financial issues may affect timely payment of your account. We encourage you to communicate any such problems so we may assist you in the management of your account.

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentists or any other member of his staff responsible for any action they take or do not take because of error or omissions that I may have made in the completion of this form.

X________________________________________________________________________________

**Signature of Patient/Legal Guardian** **Date**

# HEALTH HISTORY

Patient's Name______________________________ Date of Birth____________________

**ALLERGIES:**

- ☐ Aspirin
- ☐ Barbiturates
- ☐ Codeine
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Metals
- ☐ Other: ____________________

____________________

**MEDICATIONS:**

Please list medications you are currently taking:

____________________

____________________

____________________

____________________

____________________

**Check (☐) if you have had any of the following:**

- ☐ Alcoholism
- ☐ Anemia
- ☐ Angina Pectoris
- ☐ Arthritis
- ☐ Artificial Joints*
- ☐ Asthma
- ☐ Back Problems
- ☐ Birth Defects
- ☐ Bruise Easily
- ☐ Cold Sores
- ☐ Denture or Partials
- ☐ Diabetes: TYPE I TYPE II
- ☐ Eating Disorder
- ☐ Emphysema
- ☐ Epilepsy or seizures
- ☐ Fainting or dizzy spells
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Problems
- ☐ Heart Failure
- ☐ Heart Disease
- ☐ Heart Pacemaker*
- ☐ Heart Murmur*
- ☐ Heart Stents*
- ☐ Heart Shunt*
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ History of drug addition
- ☐ HIV Positive, AIDS
- ☐ Kidney trouble
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse*
- ☐ Persistent cough
- ☐ Rheumatic Fever*
- ☐ Seasonal Allergies
- ☐ Sinus Trouble
- ☐ Steroid Treatment*
- ☐ Stroke
- ☐ Tobacco habit
- ☐ Tuberculosis
- ☐ Ulcers

***Antibiotic pre-medication may be required prior to your appointment.**

Has a physician recommended that you take antibiotic pre-medication prior to dental treatment? Yes No

**Check (☐) if you have had any problems with the following:**

- ☐ Bad Breath
- ☐ Bleeding/tender gums
- ☐ Periodontal treatment history
- ☐ History of trauma to your jaw
- ☐ Clicking, popping or jaw pain
- ☐ Difficulty opening/closing jaw
- ☐ Difficulty chewing
- ☐ Wear a splint or night guard
- ☐ Have been diagnosed with TMJ/TMD
- ☐ Sensitivity to cold, hot, sweets or pressure
- ☐ Sores, lumps, or growths in mouth or lips
- ☐ Difficultly with extractions in the past
- ☐ Prolonged bleeding following extractions
- ☐ Taken diet drugs Redux, Pondimin, or Phen-Fen

Have you had an orthopedic total joint (hip, knee, elbow, or finger) replacement? Yes No

If yes, when was the operation done? ______________________________

Have you ever suffered a Heart Attack? Yes No If yes, date of last heart attack: ____________________

Do you have/had Cancer? Yes No Type: ____________________ Are you undergoing treatment? Yes No

Is there anything related to your medical/dental history that you have not indicated above? Yes No

If yes, please explain:______________________________

**WOMEN:** Are you pregnant now? Yes No If yes, when is your due date?____________________

Are you currently breast feeding? Yes No Are you taking oral contraceptives? Yes No