PATIENT REGISTRATION

Patient Name _____ Main contact number _____ (home / cell)

Address _____ City _____ State _____ Zip _____

Email Address _____ Alternate contact number _____ (home / cell)

Occupation _____ Employer _____

Business Address _____ Business Phone Number _____ Ext. _____

Social Security Number _____ Date of Birth _____ Circle: Male / Female

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT (Skip if same as above)

Name _____ Phone Number _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Occupation _____ Employer _____

Business Address _____ Business Phone Number _____ Ext. _____

Social Security Number _____ Relationship to Patient _____

YOUR SPOUSE

Name _____ Business Phone Number _____

Occupation _____ Employer _____ Social Security Number _____

Business Address _____ City _____ State _____ Zip _____

DENTAL INSURANCE

Primary Carrier

Employee _____ Employer _____

Insurance Company _____ Group Number _____

Social Security Number _____ Date of Birth _____

Secondary Carrier

Employee _____ Employer _____

Insurance Company _____ Group Number _____

Social Security Number _____ Date of Birth _____

GETTING TO KNOW YOU

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

Is another member of your family or relative a patient at our office?

Name _____ Relationship _____

Person to contact for emergency

Name _____ Phone Number _____

Address _____ City _____ State _____ Zip _____

Closest relative not living with you

Name _____ Phone Number _____

Address _____ City _____ State _____ Zip _____

CONSENT FOR TREATMENT/FINANCIAL RESPONSIBILITY: This is to certify that I, Undersigned: (1) Consent to the performing of the Dental Procedures agreed to be necessary or advisable, including the use of local anesthetic as indicated: (2) Consent to releasing information to my insurance company: (3) Agree to pay the fees associated with the dental procedures, including the award of thirty percent collection agency fee, all reasonable attorney's fees, at trial and on appeal, as determined by the court for the legal efforts necessary to obtain the fees.

Signature of Patient (or guardian if minor) _____ Date _____

Child Dental/Medical History

Child's Name_____ Age _____ Date of Birth _____

Is your child under the care of a physician? ..... Yes No
Name of Physician: _____

Are your child's immunizations up to date? ..... Yes No

Is this your child's first visit to a dentist? ..... Yes No
If not, how long since the last dental visit? _____

Is your child in pain? ..... Yes No

When does your child brush their teeth? Upon Rising After eating any meal Before Bed

How does your child receive fluoride? Community Water Well Water Fluoride Drops/Tablets/Rinse

Was your child: Breastfed Bottle Fed Both

Does your child use: (circle all that apply) Bottle or Sippy Cup

Does your child use: (circle all that apply) Use A Pacifier Thumb Suck Fingers

Is your child receiving any medications? ..... Yes No
If yes, please list: _____
Is your child allergic to Latex or medications? ..... Yes No
If yes, please list: _____

Has your child ever had surgery? ..... Yes No
Why/When? _____

Has your child ever had a history of the following? (circle all that apply)

ADHD/ADD	Cleft Lip or Palate	Easy Bleeding	Kidney Infections
Anemia	Coagulation Disorder	Epilepsy/Seizure Disorder	Liver Problems
Asthma	Congenital Birth Defects	Hepatitis	Long QT Syndrome
Autism or Spectrum Disorder	Cystic Fibrosis	Hearing Loss/Impairment	Prolonged Bleeding
Blood Transfusion	Developmental Delay	Heart Defect	Rheumatic Fever
Cancer	Diabetes	Heart Murmur	Sickle Cell Anemia or Trait
Cerebral Palsy	Down Syndrome	HIV/AIDS	Speech Impairment/Delay
Chronic Sinusitis	Ear Infections	Heart Repair	Syndrome

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 any action they take or do no take because of errors or omissions that I may have made in the completion of this form.

Signature_____ Date _____

WEST 10TH DENTAL GROUP

OUR MISSION

Our work is dedicated to providing exceptional dental care for patients of all ages. We strive to provide comprehensive care, educate each patient to the best of our ability, and provide a pathway to healthy smiles for life.

Name _____

Initial_____ APPOINTMENTS

Should you need to change your appointment date or time, we require a 48 hour notice to avoid a charge. This ensures we are able to offer the most convenient times to you and our other patients.

Initial_____ INSURANCE POLICIES

To assist our patients, we will file insurance claims for each visit. We accept most insurance plans and we are network providers for: Aetna PPO, Assurant, Cigna PPO, Connection Dental, Delta Dental PPO, Delta Dental Premier, Dental Blue 300, Dental Wellness Partners, Health Resources, Maverest, Metlife, United Healthcare, and Hoosier Healthwise for our Pediatric patients.

Initial_____ PAYMENT ARRANGEMENTS

Financial obstacles should not stand in the way of your healthy smile! Our office accepts cash, check, and all major credit cards. Zero interest and low interest payment plans are available through our financial partners Care Credit and Citi Health. Applications can be processed by our office or in the privacy of your own home. Any financial arrangements needed must be established prior to the time of service. Please contact us with any questions and we will be happy to assist you.

ACKNOWLEDGEMENT AUTHORIZATION/RELEASE
RECEIPT OF PRIVACY PRACTICES

□ I, _____, have received a copy of West 10th Dental Group's Notice of Privacy Practices.

_____ Date_____
(Signature)

□ I hereby authorize and request West 10th Dental Group, and/or a representative of West 10th Dental Group, to:

- Discuss my dental treatment with
- Disclose and give copies to
- Discuss my financial account with
- Disclose and give copies of financial account to

Name_____

Relationship_____ Phone #_____

Name_____

Relationship_____ Phone #_____

This will include any and all records and information concerning the undersigned which you may have in your possession, including but not limited to the following: dental records, including operative records, diagnosis, dental history, findings and procedures, treatment and interviews, radiographs, diagnostic models and additional materials.

In consideration of such disclosure on the part of the above name person or institutions, I hereby release them from any and all liability arising from such disclosure.

_____ Date_____
(Signature)

□ I hereby authorize West 10th Dental Group and/or a representative of West 10th Dental Group to contact me by the following:

- Mail
- E-mail Address_____
- Text Message
- Cell Phone
- Telephone
- Voicemail
- Answering Machine

_____ Date_____
(Signature)