AUGUSTA FAMILY DENTAL GROUP LLC

NEW PATIENT REGISTRATION FORM

Patient Information:

First Name:_____ Last Name:_____ Middle Initial:_____

Preferred Name:_____

Patient is : ☐ Responsible Party ☐ Policy Holder ☐ Dependent

Address:_____

City, State, Zip:_____

Cell Phone:_____ ☐ I would like to receive text messages

Work Phone:_____ Home Phone:_____

Sex: ○ Female ○ Male Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth date:_____ Social Security #:_____

E-mail:_____ ☐ I would like to receive email correspondences

Name of Spouse:_____

Patient Information (section 2):

Employment Status: ○ Full Time ○ Part Time ○ Self Employed ○ Retired ○ Unemployed

Student Status: ○ Full Time ○ Part Time

Preferred Physician:_____

Preferred Pharmacy:_____

Responsible Party(If other than the patient):_____ Relation:_____

Primary Phone:_____ Birth Date:_____ SS #:_____

Billing Address:_____

Primary Insurance Information:

Name of Insured:_____ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Social Security #: _____ Insured Birth date:_____

Employer:_____ Insurance Company:_____

(1) What prompted you to seek dental care at this time?_____
_____

(2) On a scale of 1 to 10 (10 being the highest), what priority do you give your teeth? _____
(3) Have you experienced any discomfort from your teeth or gums lately? Yes No
(4) Have you noticed any popping, clicking or tiredness of your jaw joint? Yes No
(5) Do you have any missing teeth that have not been replaced? Yes No
(6) Do you feel that you cannot chew well? Yes No
(7) When did you last have x-rays taken of your teeth? _____Last cleaning? _____
(8) Do you receive any type of fluoride? Yes No
(9) The name and address/phone number (if available) of your former dentist:_____
(10)Why did you choose our office for your dental needs?_____
(11)Whom may we thank for referring you to our office? _____

MEDICAL HISTORY:

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

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

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

(4) Are you taking any medications, pills, or drugs? Yes No If yes, List:_____
_____

(5) Have you ever taken Fosamax, Boniva, Actonel, or any bisphosphonates? Yes No
(6) Are you on a special diet? Yes No (7) Do you use tobacco? Yes No
(8) Do you use controlled substances? Yes No
(9) Do you need to take PRE-MEDICATION? Yes No If yes, please explain: _____

(10) Do you take aspirin or blood thinners daily? Yes No If Yes, List:_____

(11) Women: Are you Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No

(12) Are you allergic to any of the following? CIRCLE ALL THAT APPLY.
Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics
Other If other, please explain:_____

PLEASE CHECK ALL THAT APPLY, IF ANY:

Have you ever had any of the following medical conditions or allergies?

- [ ] *Premed
- [ ] ADD/ADHD
- [ ] AIDS/HIV
- [ ] Alcohol/Drug Problem
- [ ] Allergies
- [ ] Allergy Codeine
- [ ] Allergy Latex
- [ ] Allergy Other Med
- [ ] Allergy Penicillin
- [ ] Allergy Sulfa
- [ ] Anemia
- [ ] Arthritis
- [ ] Artifical Valves
- [ ] Artificial Joints
- [ ] Asthma
- [ ] Autisim
- [ ] Blood Disease
- [ ] Blood Thinner
- [ ] Cancer
- [ ] Chest Pains
- [ ] Cong Heart Defect
- [ ] Diabetes
- [ ] Dizziness/Fainting
- [ ] Epilepsy/Seizures
- [ ] Excessive Bleeding
- [ ] Glaucoma
- [ ] Growths/Tumors
- [ ] Hay Fever
- [ ] Head Injuries
- [ ] Heart Disease
- [ ] Heart Murmur
- [ ] Heart Stent
- [ ] Hepatitis
- [ ] High Blood Pressure
- [ ] Kidney Disease
- [ ] Liver Disease
- [ ] Mental Disorders
- [ ] Missing
- [ ] MVP
- [ ] Nervous Disorders
- [ ] Neurological Dis
- [ ] Other
- [ ] Pacemaker
- [ ] Pregnancy
- [ ] Radiation/Chemo
- [ ] Respiratory Problems
- [ ] Rheumatic Fever
- [ ] Scarlet Fever
- [ ] Sinus Problems
- [ ] STD
- [ ] Stomach Problem
- [ ] Stroke
- [ ] Thyroid Problems
- [ ] Tuberculosis
- [ ] Ulcers

AUGUSTA FAMILY DENTAL GROUP LLC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRACTICE POLICY

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Practice Policy Form and understand it.

Print Name: _____

Signature: _____

Today's Date: _____

For Office Use Only

We attempted to obtain a written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communications barriers prohibited obtaining this acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please Specify)

_____

_____

_____

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ACKNOWLEDGEMENT OF PRACTICE POLICY FORM

Missed Appointments

Please allow a **24hr notice** for cancelled appointments to avoid a $60.00 no-show or broken appointment fee. We understand that emergencies arise and may make an exception for such occasions.

Regarding Your Insurance

- After verifying your insurance, we will ESTIMATE the patient portion.
- We cannot guarantee the insurance policy will pay the quoted amount.
- The patient portion is due the day services are provided.
- We cannot be responsible for the specifics of each patient's insurance policy (yearly maximums, deductibles, unusual services, or usual/customary fees).
- It is the responsibility of the policy holder to understand the policy selected and the particulars of the plan. Please call your insurance company for clarification of any issues you may or may not understand prior to having services provided.

We accept cash, check, American Express, Discover, Mastercard, Visa, and Care Credit as forms of payment.

Print Name: _____

Signature: _____

Today's Date: _____