Patient Registration Form

Patient Name: _____ Date: _____

Gender: _____ Marital Status (please circle): Minor Single Married Widowed

Social Security #: _____ Birth Date: _____ Email: _____

Phone (Home): _____ Work: _____ Cell: _____

Address: _____ Apartment#:_____

City: _____ State: _____ Zip code: _____ Employer Name: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Is it okay to text you regarding any appointments or patient information? (Please circle): Yes No

Is it okay to text you regarding any statements or outstanding balance? (Please circle): Yes No

Date of Last Dental Visit: _____Previous Dentist:_____

Dental History, please check all that apply:

- ☐ Pain in any area of your mouth or teeth
- ☐ Dissatisfied with the appearance of your teeth
- ☐ Worried or apprehensive about coming to the dentist
- ☐ Problems with any previous dental treatment
- ☐ Experienced an unfavorable reaction to local anesthetic (Xylocaine, Novocain, etc)?

Have you been told you have a gum or bone problem? Clarify: _____

Have you lost many adult teeth? Clarify: _____

Have you experienced any of the following?:

- ☐ Frequently bleeding gums
- ☐ Food catching between teeth
- ☐ Burning tongue or mouth
- ☐ Frequent bad breath
- ☐ Extraction complications
- ☐ Swelling or lumps in mouth
- ☐ Clenching or grinding teeth
- ☐ Perio treatment
- ☐ Unpleasant taste
- ☐ Muscle soreness in face/neck
- ☐ Jaw popping or clicking
- ☐ Ortho treatments
- ☐ Teeth sensitivity to hot/cold
- ☐ Injury to face or jaw
- ☐ Frequent headaches

What dental aids do you use to clean your teeth? :_____

Whom may we thank for referring you to our practice?

- ☐ Another patient (Please list): _____
- ☐ Another Dental Office (Please list): _____
- ☐ Social Media/Website
- ☐ Other: _____

FINANCIAL INFORMATION:

The following is for (please circle): The patient The person responsible for payment

Name: _____Date of Birth: _____ Address: _____

INSURANCE INFORMATION: *Please only complete if you have Dental Insurance*

Primary Insurance Co:	Secondary Insurance Co:
Insured Name:	Insured Name:
Insured DOB:	Insurance DOB:
Insured SSN/ID:	Insured SSN/ID:
Insurance Co Address:	Insurance Co Address:
Insurance Phone Number:	Insurance Phone Number:
Group#:	Group#:

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any chance in my dental health, demographic information or financial information, I will inform the office at the next appointment.

_____ _____

Signature of Patient, Parent or Guardian Date

CONSENT FOR SERVICES

BROOKS FAMILY DENTAL

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager.
- If you have dental insurance, we must emphasize that as your dental provider, our relationship is with you and not your dental insurance company. Your insurance policy is a contract between you, your employer and your insurance company. If there is any remaining balance owed after your insurance company has paid their portion, it will be the patient's responsibility, or responsible party on behalf of the patient, to pay the remaining balance in full.

- **If your account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for any and all legal fees, collection agency fees, interest charges and any other expenses incurred by Provider in addition to the principal amount due.**
  _____ Please initial to confirm the above statement.

- All emergency dental services, or any dental services performed without a previous financial arrangement, must be paid at the time that services are rendered.
- I authorize the staff of Brooks Family Dental, PC to perform any necessary services needed during diagnosis and treatment. I understand that services can change in the middle of a procedure at the dental providers discretion and I am responsible for any change in expenses at the time services are rendered.
- I grant my permission to you or your assignee, to call me at home, cell or work or text to discuss matters related to this form.
- To the best of my knowledge, all of the preceding answers and information are true and correct. If I ever have a change in my demographic information, health or financial information, I will inform the office at the next appointment.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of Patient

_____ Date: _____ Relationship to Patient: _____
Signature Financial Guarantor

APPOINTMENT POLICY

At Brooks Family Dental, we put our faith in you to keep your appointment. When we set an appointment, we set aside a dedicated time just for you. This allows us to slow down and have a meaningful appointment with every patient. If for any reason you must change your appointment, it is important that you give our office ***at least 48 hours notice*** so that we may offer that time to another waiting patient.

Canceled appointments within the 48-hour window will require a phone call or text message by you to let us know that the appointment will be canceled. Cancellations within this window will be considered a missed appointment. Emergencies do happen, which is why we kindly request a phone call to evaluate case-by-case. One benefit of our practice is we get to know you, and are often willing to help.

Missed appointments will be documented in your dental record. Missed appointments are classified as appointments that were either canceled within 48 hours or if you fail to make your appointment with no notice

- If you miss 1 or more dental appointments within a six-month-period, you must pay for half of the full total of the next appointment. This payment/deposit will apply towards the services rendered. However, if you miss the rescheduled appointment, the amount paid will be applied as a non-refundable payment.
- For patients with insurance, *this deposit cannot be billed to your insurance company* and must be paid by cash, check or credit card.

Late arrivals:

- **New Patients**: We require all New Patients to complete paperwork ahead of your scheduled appointment time. If for any reason you are unable to fill out your paperwork prior to your appointment, *we require you to arrive at least 15 minutes ahead of your scheduled appointment time in order to complete all necessary paperwork*. If you arrive late for your appointment and your paperwork is not complete, you will be rescheduled to another date and time to make sure our Providers are given enough time to complete your treatment.

- **Existing Patients**: If you arrive more than 15 minutes late for your appointment, you will be rescheduled to another date and time to make sure that our Providers are given enough time to complete your treatment. If you are running late, please call us to see if we can accommodate your late arrival. Please keep in mind that some appointments are only 30 minutes, meaning that 15 minutes late is 50% of your designated time.

I have read the above conditions of scheduling and appointments and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of Patient

_____ Date: _____ Relationship to Patient: _____
Signature Parent or Guardian