Frenchtown Dental Patient Registration

Patient Name_____ Male ◯ Female ◯

(First) (Last) (Preferred)

Mailing Address_____ City_____ State____ Zip_____

Cell Phone_____ Home Phone _____ Email Address _____

Birthdate_____ Social Security #_____

Employer Name and phone number _____

If patient is not the responsible party please list name, address and phone number of responsible party:_____

_____

Insurance Information: Please present your card to the front desk

Dental Insurance Company name, address and phone number_____

Subscriber's Name_____ Social security number_____ Birthdate_____

ID Number_____ Group ID or Number_____ Group name (employer)_____

Subscriber's relationship to patient_____

2nd Insurance Information:

2nd Dental Insurance Company name, address and phone number_____

Subscriber's Name_____ Social security number_____ Birthdate_____

ID Number_____ Group ID or Number_____ Group name (employer)_____

Subscriber's relationship to patient_____

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Medical History

Patient Name: _____ Birth Date: _____ Date: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is pay of your entire body. Health problems that you may have, or medication that you may be taking can affect your oral health and treatment

Are you under a physician's care? □ Yes □ No Who: _____

Have you ever been hospitalized or had a major operation? □ Yes □ No

If yes: _____

Are you taking any medications, supplements, pills or drugs (legal or not)?
□ Yes □ No

If yes:_____
_____
_____

Do you use tobacco? □ Yes □ No

Women: Are you…

□ Pregnant/ trying to get pregnant □ Nursing

Are you allergic to any of the following?

□ Asprin □Penicillin □Codein □Acrylic □Metal □Latex

□Sulfa Drugs □Local anesthetics □Other: _____

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Do you have, or have you had any of the following?

□AIDS/ HIV positive
□Alzheimer's disease
□Drug addiction
□Angina
□Epilepsy or seizures
□Hives or Rash
□Asthma
□Frequent Cough
□Leukemia
□Liver Disease
□Swelling of Limbs
□ Thyroid Disease
□Chest Pains
□Cold Sores
□Congenital Heart Disorder
□Cortisone Medicine
□Diabetes
□Anemia
□Emphysema
□High Cholesterol
□Artificial Joint
□Fainting Spells/Dizziness
□Kidney Problems
□Stomach/Intestinal Disease
□Stroke
□Cancer
□Chemotherapy
□ Heart Attack/ Failure
□Heart Murmur
□Heart Pacemaker
□Heart Trouble
□Hemophilia
□Hepatitis
□Easily Winded
□High Blood Pressure
□Artificial Heart Valve
□Excessive Thirst
□Sinus Trouble
□Spina Bifida
□Breathing Problems
□Glaucoma
□Hay Fever
□Osteoporosis
□Pain in Jaw Joints
□Obstructive Sleep Apnea
□ Psychiatric care
□Radiation Treatments
□Anaphylaxis
□Herpes
□Arthritis/Gout
□Excessive Bleeding
□Hypoglycemia
□Blood Disease
□Blood Transfusion
□Frequent Headaches
□Low Blood Pressure
□Lung Disease
□Tonsillitis
□Tuberculosis
□ Tumors or Growths
□Ulcers
□Jaundice

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Have you ever had any serious illness not listed above?

_____
_____
_____

Do you have a family history of any of the following?

□Diabetes □ Heart Attack/ Failure □Sleep apnea □Cancer □Periodontal Disease

Emergency Contact: _____ Phone#:_____

Relationship: _____

If you could change something about your smile what would it be?

_____
_____
_____
_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____ _____

Signature of Patient or Guardian Date

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Sleep Screening Questionnaire

Please answer the questions below to help us assess the possibility of a sleep disorder which may be related to your dental and overall health. There is often a correlation between grinding of the teeth, TMJ disorders, breakdown of the teeth and sleep disorders. Sleep apnea may also increase your risk for many different health conditions including heart attack and stroke. If you are here with your child (under 16), please fill out the lower portion marked "For children only" for your child.

Name:_____ **Height:**_____ **Weight:**_____

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired?

0 = I would never doze
1 = I have a slight chance of dozing
2 = I have a moderate chance of dozing
3 = I have a high chance of dozing

Situation	**Chance of Dozing**
1. Sitting and reading	_____
2. Watching TV	_____
3. Sitting inactive in a public place (e.g. a theater or a meeting)	_____
4. As a passenger in a car for an hour without a break	_____
5. Lying down to rest in the afternoon when circumstances permit	_____
6. Sitting and talking to someone	_____
7. Sitting quietly after lunch without alcohol	_____
8. In a car while stopped for a few minutes in traffic	_____
Total Score	_____

Have you ever been diagnosed with:	**Yes**	**No**
1. Impaired Cognition (i.e. difficulty concentrating or thinking)	☐	☐
2. Mood Disorders/Depression	☐	☐
3. Insomnia	☐	☐
4. Hypertension (high blood pressure)	☐	☐
5. Ischemic Heart Disease (Coronary Artery Disease/Atherosclerosis)	☐	☐
6. History of Stroke	☐	☐
7. Sleep Apnea	☐	☐
If yes: Did you try to use CPAP	☐	☐
8. TMJ problems significant enough to require treatment	☐	☐
9. Gastric Reflux (GERD) or Heartburn	☐	☐

Are you aware of (or have you been told):	**Yes**	**No**
1. Snoring on a regular basis	☐	☐
2. Feeling tired or fatigued on a regular basis	☐	☐
3. Clenching or grinding your teeth (bruxism)	☐	☐
4. Having frequent headaches	☐	☐
5. Your neck size being > 17 inches (male) or > 16 inches (female)	☐	☐
6. Anyone in your family having sleep apnea	☐	☐
7. Stopping breathing when sleeping/awakening with a gasp	☐	☐

For children only (filled out by parent or guardian)

Are you aware of your child:	**Yes**	**No**
1. Snoring/noisy breathing while sleeping	☐	☐
2. Grinding his or her teeth	☐	☐
3. Wetting the bed	☐	☐
4. Having difficulty in school/learning	☐	☐
5. Being treated for ADD or ADHD	☐	☐
6. Breathing primarily through their mouth	☐	☐
7. Having frequent nightmares/night terrors	☐	☐
8. Having frequent ear aches	☐	☐

Dental Exam Findings:

- ☐ **Evidence of Bruxism**
- ☐ **Scalloping of the tongue**
- ☐ **Crowded airway**
- ☐ **Tori or Bone Loss**
- ☐ **Anterior wear**
- ☐ **Retrognathia / Class II**

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FINANCIAL AGREEMENT AND POLICY OF CARE

- For patients without dental insurance, full payment for professional services is expected at the time of treatment
- For patients with insurance: The insurance contract is between you and the insurance company, they are the ones who make the final determination on coverage and payment. We are only able to provide estimates. Co-pays will always be due at time of treatment. After insurance pays their portion there may be a balance which you are responsible for.

Our payment options are as follows:

a. Pre-payment for treatment; A 5% bookkeeping courtesy is available for those who pay the full cost of their treatment, with cash or check, before treatment is started.
b. Cash, check, Visa, Mastercard or Visa payments at time of appointment.
c. Major Credit Card:
    i. We accept Visa, MasterCard and Discover
d. In office financing through Care Credit:
    i. 6-12 month interest free financing is available through our health spending banking partner Care Credit

- Please review the following statements:
    - I understand that I am responsible for the full amount of service
    - I assign my insurance benefits to Frenchtown Dental
    - I give my permission for Frenchtown Dental to disclose my account/ treatment information to appropriate agencies
    - I understand that all balances shall be subject to a service charge of 5% per month until paid in full.
    - I understand any treatment which does not have a payment plan shall be considered delinquent and subject for collection action if unpaid for 90 days or more from the date incurred. I am responsible for any collection fees including but not limited to- attorney fees, agency fees (up to 50% of my account balance may be added and I am responsible for that amount).
    - I understand that a $30 fee will be applied for any returned checks
    - I understand this form is valid unless I cancel the authorization through written notice.
    - This document supersedes all previous financial agreements

Cancellation and Broken Appointment Policy

We understand that emergencies do occur. We ask our patients to give us 48 hour notice if you cannot keep an appointment.

Failure to give notice: At our discretion, broken appointment will be subject to a rescheduling fee. A $50 deposit will be necessary to reschedule the broken appointment and will be applied to the scheduled service if the next appointment is kept. If the next appointment is broken then the $50 deposit will be forfeited.

Definition of "Broken Appointment": A broken appointment is: Cancel or reschedule of an appointment with less than 24 hour notice, or in the case of a no show for a scheduled appointment.

Our number one concern is our patients' dental health. Providing services in a timely manner is critical to accomplishing that goal. The appointment you schedule for treatment is reserved for you and your treatment only. When you fail to keep your appointment without providing us adequate notice, this adds to the overall cost of care. We appreciate your understanding and consideration regarding our appointment policy and if you have any questions or concerns, never hesitate to ask us at Frenchtown Dental.

I have read and understand the above policies.

Patient signature (Parent)_____ Date: _____