Patient Registration Form

Date: _____

Name _____ Mr. Mrs. Ms. Miss Dr. Rev.

Address _____ City _____ State _____ Zip _____

Date of Birth _____/_____/_____ Marital Status S M D W Home Phone (____)_____

Soc. Security # _____-_____-_____ Sex M or F Work Phone (____)_____

E-mail _____@_____ Cell Phone (____)_____

Employer Name & Address _____ Occupation _____

Spouse Name _____ Spouse Date of Birth _____/_____/_____

Emergency Contact _____ & Phone Number (____)_____

How Did you hear about our office? _____

Dental Insurance Information

Insurance Subscriber _____ Relationship _____ Date of Birth _____/_____/_____

Employer Name and Address _____ ID #_____

Dental InsuranceCo. _____ Address _____

Phone # of Insurance Co. __(____)_____ Policy/Group #_____

Secondary Dental Coverage? YES or NO If yes, please provide information on your coverage. We will be happy to file your secondary claim for you. You are responsible for all co-payments before secondary insurance is filed. Your secondary insurance will be instructed to reimburse you directly.

Secondary Insurance Co. Name, Address, and Phone ____

_____

I understand that I am responsible for the cost of this care regardless of insurance coverage and deductibles. I authorize the release of information as it relates to my dental treatment and my insurance coverage. I also acknowledge that I have received a copy of the office "Privacy Policy" as required by the Health Insurance Portability & Accountability Act (HIPPA).

Signature _____ Date _____

Please complete other side of this form with your Dental and Medical History

Dental History

Reason for today's visit? _____

At the present time, do you have any dental complaint or concerns? _____

When was your last dental visit? _____ Previous Dentist's Name _____

Previous Dentist's Address _____ Phone (____)_____

Medical History

Are you presently under the care of a Physician? _____ Physician's Name _____

Physician's Address _____ Phone (____)_____

Has there been any change in your general health in the last year? YES or NO If yes, please explain:

_____

Date of last physical examination ____/____/____ Please list any medications, including non-prescriptions, which you are currently taking _____

Have you had any serious illness, operations, or been hospitalized in the last 3 years? YES or NO

If yes, please explain _____

Y	N	Conditions
☐	☐	Anemia
☐	☐	Arthritis
☐	☐	Artificial Heart Valve
☐	☐	Artificial Joints
☐	☐	Blood Transfusion
☐	☐	Cardiac Pacemaker
☐	☐	Chemical Dependency
☐	☐	Circulatory Problems
☐	☐	Cortisone Treatments
☐	☐	Diabetes
☐	☐	Dialysis
☐	☐	Fainting Spells
☐	☐	Frequent Headaches
☐	☐	HIV + AIDS
☐	☐	Heart Disease
☐	☐	Heart Murmur
☐	☐	Hepatitis
☐	☐	High Blood Pressure
☐	☐	Jaundice
☐	☐	Kidney Problems
☐	☐	Low Blood Pressure

Y	N	Conditions
☐	☐	Mitral Valve Prolapse
☐	☐	Organ Transplants
☐	☐	Pain In or Near Ears
☐	☐	Prolonged Bleeding
☐	☐	Psychiatric Problems
☐	☐	Respiratory Disease
☐	☐	Rheumatic Fever
☐	☐	Seizures
☐	☐	Sinus Problems
☐	☐	Stroke
☐	☐	Tattoos
☐	☐	Thyroid Condition
☐	☐	Tuberculosis
☐	☐	Tumors or Growths
☐	☐	Ulcer / Stomach Problems
☐	☐	Venereal Disease

If female please answer the following:

☐	☐	Are you taking Birth control?
☐	☐	Are you pregnant?
☐	☐	Are you nursing?

Y	N	Allergies
☐	☐	Asprin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline

Other _____

_____

_____

Office Notes

Pre-med YES or NO

I attest to the accuracy of the information on this form and hereby authorize Dr. Mizrachi or designated staff to perform necessary dental treatment mutually agreed upon by me as may be required for proper dental care.

Signature _____ Date _____

Office Policy

We would like to welcome you to our dental practice and explain a little about our office policies and goals. We believe in the theories of modern dental care which do not support the old premise of "When it hurts - fix it". Through proper preventive care and regular checkups, we believe that it is highly likely that most of our patients can expect to keep all of their teeth for many years to come.

Our patients can expect from us:

1. A high degree of professional skill and ability.
2. A dedication to your oral healthcare.
3. A minimization of costly reconstructive work through proper preventative care.
4. The highest effort to make your visits as comfortable as possible.
5. The right treatment at the right time.
6. Fees that are fair and just for the services provided.

In return, we expect from our patients:

1. Cooperation in making and keeping appointments.
2. A conscientious effort toward good oral hygiene.
3. Recall visits to maintain optimum oral health.
4. Arrangement for the payment of fees at the time of service.

Insurance:

1. As the policy holder or insured person you should be aware of your insurance plans coverage.
2. For any treatment plan provided for a patient we present an estimation of what an insurance company covers. *This is an estimate not a determination of payment.*

In order for our newly formed relationship to be mutually satisfying and beneficial, we ask that at any time you have a question or are unhappy about any treatment, fee for service, or attitude of our dental team, please discuss it with us promptly and openly.

Misunderstandings and/or lack of communication are the only obstacles to our continued friendship and professional relationship.

Again, we welcome you and look forward to seeing you soon.

Sincerely,

Avi Mizrachi D.D.S.

Patients Signature _____