PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

	DATE				1		DENTAL INSURANCE 2		
Δ	LAST NAME FIRST				M.I.	1	PRIMARY CARRIER		
	PREFERS TO B	E CALLED BY					INSURANCE COMPA		
летніs \	ADDRESS					-	GROUP NO.	NO.	
APPOINTMENT	CITY		STATE		ZIP	-	EMPLOYER NAME		
IS FOR YOU START HERE	HOME PHONE NO. FAX					1	INSURED'S NAME		
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. •	BIRTHDATE	AGE	MALE	FEI	MALE		INSURED'S I.D. NO.		
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Relationship to Patient

☑ 002/006

Patient's Signature

Parent/Responsible Party's Signature

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs,

	and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) <u>'s</u> dental needs.
2.	Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3.	I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4.	I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.
5.	I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Name	Yes Yes Yes Other Yes Yes Yes Yes Yes Yes Yes Yes	No No No No No No
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FORM 015 (11.07)

1.800.925.2600

www.prideinstitute.com

Patient Name		
		DENTAL HISTORY
Patient Account No.	Medical Alert	
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Welcome! So that we may provide you with the best possible care please complete both sides of this medical/dental history form.

All information is completely confidential.

What was done at your last dental visit? Previous Dentist's Name Address Telephone How often do you have dental examinations? How often do you brush your teeth? Have you ever used or are currently using topical fluoride? Yes No What other dental aids do you use? (Interplak, toothpick, etc.) Do you have any dental problems now? Yes No If yes, please describe: Are any of your teeth sensitive to: Hot or cold? Sweets? Biting or Chewing? Have you noticed any mouth odors or bad tastes? Do you frequently get cold sores, blisters or	lo	Hov	r often do	o you floss?	
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Biting or Chewing? Have you noticed any mouth odors or bad tastes? Do you frequently get cold sores, blisters or	Yes Yes	No No		Orthodontic treatment? Yes	No
Have you noticed any mouth odors or bad tastes? Do you frequently get cold sores, blisters or	Yes		*	Oral Surgery? Yes	No
Do you frequently get cold sores, blisters or	Yes	No No		Periodontal treatment? Yes	No
	162	140		Your teeth ground or the bite adjusted? Yes	No
	Yes	No		A bite plate or mouth guard? Yes	No
any other oral lesions?	165	MO		A serious injury to the mouth or head? Yes	No
Do your gums bleed or hurt?	Yes	No		If so, please describe, including cause	
Have your parents experienced gum disease	100	INU			
	Yes	No		House you everelleneed	
Have you noticed any loose teeth or change	160	140		Have you experienced: Clicking or popping of the jaw? Yes	N.
	Yes	No		Clicking or popping of the jaw? Yes Pain? (joint, ear, side of face) Yes	No No
Does food tend to become caught in between	.100	110		Difficulty in opening or closing the mouth? Yes	No
	Yes	No		Difficulty in chewing on either side of the mouth? Yes	No
If yes, where?	100	110		Headaches, neckaches or shoulder aches? Yes	No
		٠		Sore muscles (neck, shoulders)? Yes	No
Do you:				Colo macolos (noch, shouldoto).	110
	Yes	No		Are you satisfied with your teeth's appearance? Yes	No
	Yes	No		Would you like to keep all of your teeth all of your life? Yes	
Hold foreign objects with your teeth?					
	Yes	No		Do you feel nervous about having dental treatment? Yes	No
Mouth breathe while awake or asleep?	Yes	No		If so, what is your biggest concern?	
	Yes	No			
	Yes	No		Have you ever had an upsetting dental experience? Yes	No
Smoke/chew tobacco or use other tobacco products?	Yes	No		If yes, please describe	
Have you ever been told to take a pro modication prior to death treat	· tmant	· .	,		
Have you ever been told to take a pre-medication prior to dental treat is there anything else about having dental treatment that you wo			lan a co	Ye Ye	

(Please complete other side)

Dr. Chang-Lowe Family Dentistry 536 Health Blvd Daytona Beach, FL

Financial Policy Guidelines

We accept cash, personal checks, Visa, Master Card, Discover or Care Credit. If you are interested in signing up for Care Credit, please advise us. Returned checks are subject to a service charge.

Self-Pay patients are responsible for full payment at the time of service.

Co-payments, deductibles and any outstanding balances will be collected at the time of service.

At each visit, you will be asked to provide your insurance card. As a courtesy, we will file your insurance claim. If payment is not received from your insurance company within a reasonable time, the balance becomes the patient's responsibility. Any balance on your account after 90 days, including those that your insurance has not paid, can result in collection action.

We realize that emergencies do arise and may affect timely payment of your account. If such extreme cases do occur, please contact our office at (386) 255-3644.

CANCELLATION POLICY: If you find it necessary to cancel and reschedule your appointment, we require a 24-hour notice. If you do not give a 24-hour notice or if you do not show for you appointment there will be a \$45 cancellation fee for missed 1 hour appointments and \$80 cancellation fee for missed appointments scheduled for more than 1 hour. In order to reschedule missed appointments we will require a \$100 non-refundable deposit. This deposit must be paid prior to receiving a new appointment, and as long as you keep your appointment, the deposit will be applied to your account. Any remaining monies will be mailed to you after the fees for treatment have been paid.

Patient's Name (Please Print)	have read and understand t	he financial policy	,
Patient's Signature		Date	_